MENTAL HYGIENE

VOL. VI OCTOBER, 1922 No. 4

BODY AND MIND: THE ORIGIN OF DUALISM*

SIR FREDERICK MOTT, K.B.E., M.D., F.R.S.

Pathologist to the London County Mental Hospitals; Director, Pathological Laboratory, Maudsley Hospital

THE problem of body and mind, or body and soul, is as old as civilization. The evolution of language has led to a dual terminology, the origin of which I shall point out later. So long as man analyzes his own feelings, so long must he use language in order to express to others his thoughts and so long must he have two sides to his nature—a bodily and a mental side; accordingly he is accustomed to accept this duality as obvious. At the present time human beings, with few exceptions, accept this duality of body and mind, and language is accordingly impressed with the idea of dualism, and we should not be understood by the majority of people if a new terminology were invented.

Dualism has been reaffirmed by experimental psychologists of the Wundt school, who have advanced the doctrine of psycho-physical parallelism which teaches that the series of bodily events and the series of psychic events stand in an inseparable correlation to one another; but that body and mind, though existing side by side, are separate. This is really a modification of the preëstablished harmony of Leibnitz, which Kant had already expressed in a special form. Now if we inquire into the origin of this dualism which exists in all human beings—savages, primitive people, or cultured people—we shall see that it is centered around death; the evidence of

* An address delivered before the Medical Society of Charing Cross Hospital on Tuesday, December 13, 1921. Reprinted through the courtesy of *The Lancet*.

burial rites and customs universal in the bronze and neolithic ages shows that prehistoric man believed in an intangible, invisible spirit which left the body at death. The doctrines of the wandering souls of the Egyptians, of the stories of the Old Testament, of Homer, who speaks of life "flitting away like a dream", affirm that the body and soul are separable, are two different things, which during life stand in close connection with one another, but which are separated at death. There was also the prevalent belief that evil spirits could take up their abode in the body; insanity was thus accounted for, and it appears from a recent letter in the press that there are even doctors of the present day who believe in demonology. I suppose general paralysis of the insane in older days would have been attributed to an evil spirit, but we now know that it is due to the spirochæte of syphilis which has taken up its abode and multiplied in the brain.

It is probable that dream life has played a considerable rôle in the foundation of the belief in a soul that can leave the body and return; for in dreams people are carried away to far distant lands, talk to their friends, see and converse with those long since dead, and a natural inference is that in sleep some spirit leaves the body and wanders away—something invisible which has sensibility, feels, thinks, and acts, the same thing that leaves the body at death. This invisible, intangible something, the soul, is either feared or honored, and the whole mode of abstract thought of primitive people is centered round this point of view.

The problem of body and mind, and body and soul, was discussed by the ancient philosophers, and it is interesting to observe that the doctrine of Lucretius, based partially on the teaching of Democritus and Leukippos, was monistic. He considered the soul to be the vital impulse of all the organs and tissues of the body. The mind is in the head, which directs and controls the whole body. He states that "the mind is begotten with the body, grows up with it, and grows old along with it". There is much truth in this doctrine of Lucretius.

The furniture of the mind is the memory of experiences and the bonds that united them from infancy onwards. But the inborn characters play a very important part, not only in the development of the body, but also in that of the mind. These

inborn qualities are psycho-physical energy, educability, imagination, emotivity, temper, and a mental balance which depends upon the harmonious interrelation and integration of those qualities of the soil upon which the mind grows up along with the body. The inborn germinal qualities are dependent upon sex, race, and ancestry, and, combined, impress a personality on every individual that profoundly affects his reaction to environmental influences in response to the three primal instincts of self-preservation, propagation, and the herd instinct of conforming to social customs, traditions, and usages. Galton's inquiry into the history of similar and dissimilar twins showed that mental and bodily resemblances occurred in similar twins, and that whereas dissimilar twins brought up under the same environmental influences remain dissimilar as regards the innate qualities of mentality, similar twins brought up under different environmental influences remained the same. Before considering the mind in relation to the study of the brain in mental deficiency, I will give a short description of the history of the brain as the seat of the psyche or soul.

Aristotle considered that the psyche was in the heart and that the brain was a cooling organ. Hippocrates, the father of medicine, localized the psyche or mind in the brain, and this doctrine was upheld by Galen. Most authorities of the Middle Ages accepted the doctrine of Galen that the brain is the organ of mind or psyche; the Cartesian doctrine—according to which the mind was regarded as an invisible, intangible something inhabiting the body and not to be dissociated from the brain—localized the soul's dwelling place in the hollow spaces (ventricles) of the brain. Descartes, wishing to materialize the soul and being unable wholly to discard the Cartesian doctrine, localized the soul in a small gland, the pineal, situated in the center of the ventricles. Swedenborg, profiting by the discovery of the compound microscope by Leuwenhoek, localized the psyche in the cells of the great brain (cerebrum); these cells, of which there are millions, he called cerebellula. Then came Gall, who argued that the mind must be in the great brain, seeing that man's faculties were so much superior to those of animals, and that the great difference between the brains of men and the brains of animals was

in the size of the cerebral hemispheres. He also demonstrated the fact that this part of the brain was diseased and wasted in lunatics and idiots. The remarkable work of Gall is forgotten, and his name is generally associated only with the exploded doctrine of phrenology. In 1876 came the experiments of Fritsch and Hitzig, and later of Ferrier, and the establishment of the doctrine of cerebral localization; although the clinical observations of Dax and Broca, of Bastian and Wernicke, had demonstrated the fact that injury or disease of the left hemisphere in right-handed persons led to various forms of aphasia according to the seat of the lesion, and Hughlings Jackson, by clinical observations, had foretold localization of movements in the cortex. It was hoped that further observations in this direction would lead to the understanding of the higher functions of mind in relation to body.

But it was Darwin's theory of evolution and the descent of man that revolutionized biological science and led to the greatest advance in our knowledge of body and mind. His theory dispensed with dogma and tradition, enabling psychology to be placed under the biological sciences, with the result that many of the younger psychologists—especially those who are concerned with the study and treatment of disorders and diseases of the mind—have regarded psychology from a biological point of view. A pioneer in that direction was Henry Maudsley. In support of this view, I will quote a passage from the *Descent of Man* (page 79):

"It has, I think, now been shown that men and the higher animals, especially the primates, have some few instincts in common. All have the same senses, intuitions, and sensations, similar passions, and even the more complex affections and emotions, such as jealousy, suspicion, emulation, gratitude, and magnanimity. They practice deceit and are revengeful. They are sometimes susceptible to ridicule and even have a sense of humor. They feel wonder and curiosity; they possess the same faculties of imitation, of attention, deliberation, choice, memory, imagination, and association of ideas and reason, though in very different degrees.

"The individuals of the same species graduate in intellect from absolute imbecility to high excellence. They are also liable to insanity, though far less often than in the case of

man. Nevertheless, many authors have insisted that man is divided by an inseparable barrier from the lower animals by his mental faculties. I formerly made a collection of about a score of such aphorisms, but they are almost worthless, as their wide difference and number prove the difficulty, if not the impossibility, of the attempt. It has been asserted that man is alone capable of progressive improvement; that he alone makes use of tools, of fire, domesticates other animals, or possesses property; that no animal has the power of abstraction or of forming general concepts, or is self-conscious and comprehends itself; that no animal employs language; that man alone has the sense of beauty, is liable to caprice, has the feeling of gratitude, believes in God, or is endowed with conscience."

Darwin says: "I will hazard a few remarks on the more important and interesting of these points." He then gives a number of examples in animals in support of his theory. At the same time he admits freely that no animal is self-conscious, if by this term it is implied that he reflects on such points as whence he comes or whither he will go, or what is life and death, and so forth. But how can we be sure that an old dog with an excellent memory and some power of imagination, as shown by his dreams, never reflects on his past experiences, pleasures, and pains in the chase? This would be a form of self-consciousness. On the other hand, how little can the hard-worked wife of an Australian savage, who uses very few abstract words and cannot count above four, assert her self-consciousness and reflect on the nature of her own existence?

Remarking upon language, Darwin observes that the dog expresses in five or six different barks or tones our cries of pain, fear, surprise, anger—together with their appropriate actions; and the murmurs of a mother to her beloved child are more expressive than any words. Mrs. Leslie Stephens says that a dog does frame a general concept of cats or sheep and knows the corresponding words as well as a philosopher; and the capacity to understand is as good a proof of vocal intelligence, though in an inferior degree, as the capacity to speak. The difference in mind between man and the higher animals, great as it is, is certainly one of degree and not of kind (Darwin).

There are three primal instincts common to men and animals: self-preservation, propagation, and the herd instinct; and these three instincts are the springs from which the streams and rivers of mental activity flow. From the biological point of view, we must regard the body as a commonwealth of cells which has developed from a single cell—the fertilized ovum. Whether we trace its development ontogenetically or phylogenetically, we see the same order of things—increasing complexity and differentiation of structure and function, which necessitates an increasingly complex harmonious interrelation and integration of function for the commonwealth of the organism. In this respect it is very much like the social organism. This harmonious interrelation is brought about by (1) bio-physical processes in the nervous system, and (2) by bio-chemical processes in the organs and tissues of the body, the products of which are conveyed by the blood and lymph streams. Whereas cerebro-spinal sensori-motor processes can be precise, discriminative, and limited in intensity and duration, and therefore capable of infinite variety and refinement by progressive evolution, the bio-chemical processes—although capable of an extraordinary discriminative sensitivity—must be diffuse in their effects, unless they act indirectly through the nervous system. Although the brain is the organ that stores the memory of past experiences and the bonds that unite and recall them, thereby enabling the individual to adapt himself to environment in the struggle for existence, yet, strictly speaking, the mind is directly dependent upon the vital activities and harmonious interactions of all the organs and tissues of the body; for of what use would the brain be without the peripheral sense organs and the nerves that connect them with the brain and spinal cord? These are the avenues of intelligence, as was clearly recognized by Aristotle in his famous dictum, *Nihil in intellectu quod non fuerit prius in sensu*, which would be more correct if *et in motu* were added. But another fundamental function of the brain, besides the life of external relation, is the consciousness of the individual's own personality, his appetites and desires, which are due in great part to the organic and bodily sensibility that without cessation makes him aware of his existence and needs.

The vital impulse is in every part of the body, and it is certain that the more active the vital impulse in an organ or structure, the greater automatically is the supply of oxygen by the blood. Every particle of the body is as much alive as the whole and possesses a bio-chemical memory. In proof of this we know that immunity against disease is due to the body's having once defended itself against the toxins of a pathogenic micro-organism; its tissues are thereby sensitized against this particular poison, so that should the organism again attempt to enter the body, the defensive mechanisms are immediately mobilized and the organism destroyed before it can multiply in the body. Still more remarkable is the condition termed anaphylaxis, or an acquired hypersensitivity of the organs and tissue of the body against foreign substances, especially proteins. Thus, if horse serum is introduced into the body, all the tissues of the body are sensitized to resist this foreign substance; and this sensitivity, which is connected with colloidal changes in the tissues, increases day by day, so that after a week or ten days, especially in certain people with an idiosyncrasy, the introduction of a fresh dose of horse serum produces such an intense colloidal reaction in the tissues that shock, sometimes fatal, may occur.

A physical or chemical stimulus, connected with the primal instincts of self-preservation by the avoidance of pain and the capture of food, of propagation, and of the bonds of union of the herd, has continued for countless ages in the process of evolution and survival of the fittest, and a specific bio-rhythm to particular stimuli subserving these primal instincts has become fixed and organized in the bodily structures, especially of the nervous system, constituting thus a physiological basis for instinctive action. Associated with these primal instincts are the primitive emotions, or certain states of feeling and bodily reactions common to men and animals. These instinctive reactions may take place independently of consciousness—e. g., the decerebrate dog will, if it be injured, attempt to run away and it will turn its head round and show anger by exposing its canine teeth. Again, Goltz showed that a dog that had had the whole of its brain cortex removed had completely lost its memory, for it invariably showed anger at the approach of the man who daily fed it. This same dog also exhibited

the emotion of disgust, for nothing would induce it to eat meat made bitter with quinine—not even starvation.

The higher we rise in the evolutional scale, the more are these instinctive reactions brought under control by the highest functions of the brain. But Nature is unmindful of the individual and mindful only of the species, and in order that the self-regarding sentiment of man should not outweigh the instinct of propagation, has predetermined an urgent desire and attraction to the opposite sex accompanied by intense pleasure in the gratification of the sexual appetite. This desire, upon which so many of our mental activities directly and indirectly depend, is primarily due to the sensitizing influence of bodily structures on the brain, and I will now dwell a little more fully upon this point of view regarding body and mind.

The sexual hormones (from *hormao,* I excite), which determine the mental and bodily characters of the two sexes, are produced by special interstitial cells contained in the reproductive organs of the two sexes, and these hormone cells can and do functionally act independently of the germ cells. They exist prior to birth, and having determined the sex characters in the infant male, they soon disappear or pass into a resting stage until puberty, when they reappear and determine the secondary male sexual characters; a complete mental revolution then occurs and a vague longing, followed by an attraction to the opposite sex, is determined by the sensitizing influence of their internal secretion on the brain. If these cells are destroyed, sexual desire is lost. Many other facts could be quoted to show the profound influence of the internal secretions of the sex glands on mind and body. Another fact that speaks of the intimate relation of the sex organs to mind is the fact that a large proportion of the cases of true insanities or psychoses and psychoneuroses commence at the times when the sex instinct matures and wanes.

Again, the influence of the secretion of the thyroid gland on the development of the brain is shown by the fact that its absence in the infant is associated with cretinous idiocy. Administration of the gland permits the brain to grow and with it the mind develops. Older people, especially women at the change of life, suffer with a failure of secretion of this

gland, and a curiously characteristic bodily condition, known as myxœdema, occurs. With this there is a disappearance of the energy substance in the brain cells, and slowness of thought, slowness of speech, and frequently mental disorder. Administration of the gland restores the body and mind if it is not begun too late. Another ductless gland, which is no larger than a bean, seated in a little bony saddle (sella turcica) at the base of the skull, controls the growth of the body and is intimately associated with the reproductive organs. Still another gland, the suprarenal, contains a store of adrenalin which, when it is discharged into the circulation, stimulates the sympathetic nerves; automatically, under the exciting influence of the emotions of fear and anger, this substance, so discharged, acts as a powerful defense mechanism in the instinct of self-preservation by causing a rise of the blood pressure, a mobilization of sugar for the production of energy by the muscles for fight or flight, a stimulation of the heart's action, increase of the blood supply to the muscles, and increased coagulability of the blood, so that wounds are less likely to be fatal. Again, there is an intimate association between the development of the brain and the cortex adrenalis; also, between this endocrine organ and the reproductive functions.

I might go on at great length showing the importance of these ductless glands and of the autonomic nervous system in relation to the primal instincts and emotions.

In daily life human beings are largely occupied in the performance of purposeful habits having their origin in the satisfaction of these primal instincts common to men and animals; they are acquired consciously by imitation or invention, but, when perfected, the will has merely to initiate the action and the sensori-motor reflex mechanism unconsciously carries on. It may be considered that in the subconscious mind there are a series of reflex patterns which, when once started, proceed in orderly sequence, the pattern of the last incoming sensory stimuli serving as the pattern of the next coördinating directing motor stimuli. The highest psychic level (consciousness) does not take any active part, but is watchful that the purpose willed is fulfilled; for it exhibits awareness when this series of reflex patterns is interrupted or inefficient. We know from

experience how fear and apprehensive self-consciousness may interfere with the efficiency of any habitual action.

In proportion to the evolution of society and the progress of civilization, the social instinct comes to dominate more and more human thought and behavior. The bond of union whereby the members of the herd are willing to sacrifice individual interest and even life is the primal source of preservation for the herd, and to a certain extent, therefore, for its individual members. This instinct of the herd is, however, a device of Nature for the preservation of the species. It has played in man a predominant rôle in the evolution of language and abstract thought and the advance thereby of culture and civilization. The habits, customs, and social usages of the herd dominate human life in thought and behavior and they serve to control the instincts. Owing to overpopulation and crowding in cities, there has arisen among highly civilized people an increasing tendency to a disharmony between social and physiological conditions regarding the sex instinct and its natural gratification. The correlation of body and mind is conclusively shown by the fact that a complete mental revolution peculiar to each sex occurs in adolescence, and with it comes a new and great source of psycho-physical energy, the vital impulse to propagate, which the social instinct, impelled by the stress of self-preservation, is enforced to control by contraceptive methods, or—using Freud's expression—to sublimate, that is, direct into other channels—e. g., religion, art, music, literature, and sport.

The social habits, customs, and usages of the herd were and are still too often based upon tradition and dogma connected with mysticism and beliefs in the supernatural regarding body and mind and body and soul, and before biological science was illuminated by the theory of evolution, few people ventured to differ from the herd regarding dualism. We now realize that in each individual life the furniture of the mind is the memory of the conscious and unconscious experiences and the bonds that united them. There can be no mind without memory, and there can be no memory without body, seeing that all psychic processes are dependent upon oxidation processes of a bio-chemical nature. We cannot separate psychical from physiological processes.

The ego is aware of his individual personality by the continuum of subjective feelings arising from the whole body in its relation to its integral parts and as a whole to the external world. All experiences of the ego attended by deep feeling and emotional discharge strike at the very roots of the three primal instincts, and the physico-chemical changes therewith reverberate and reverberate in the preorganized emotive subconscious sensori-motor and vegetative systems. These nervous and bio-chemical preorganized mechanisms, which have progressively developed in the animal body as a result of evolution in the long procession of countless ages, have become endowed with a specific bio-rhythm attuned to the primitive self-conservative animal emotions—e. g., anger, fear, disgust, and the tender emotions connected with the sexual instinct. The sentiments and passions which are the outcome of the evolution and interaction of the primitive emotions with the established bonds of union of the herd are likewise endowed with a specific bio-rhythm. Consequently, an experience with an intense emotional tone, long after it has left the field of consciousness, may be still operating subconsciously by the involuntary and unconscious bodily expression of the emotions exciting the associated subconscious memory of the emotional experience, and this in its turn reacts on the body. A vicious circle is thus established by which we may explain (1) the perseveration of the hysterical derangements of mind and body caused by emotional shock, and (2) anxiety neuroses with a mental conflict involving a struggle between the instinct of self-preservation and the social instinct of the *amour propre*.

Hysterical disabilities afflicted a large percentage of the rank and file of the conscript armies in the Great War. The emotion of fear and the wish to escape an intolerable situation led by auto- and hetero-suggestion to various bodily defensive mechanisms, in the nature of hysterical paralyses, tremors, contractures, mutism, blindness, deafness, and their perseveration. These could be prevented largely by suggestion associated with good discipline, morale, and *esprit de corps*. It was found that the number of cases in a regiment increased enormously where these were absent.

Men who had long suffered with tremors, contractures,

paralyses, mutism, and other disabilities which they had come to believe were permanent, were sent to me and were cured in a few minutes, a few hours, or a few days by various modes of contra-suggestion and persuasion, and, when cured, it was astonishing how completely changed was their mental attitude: the trembling, the cold blue hands and feet, the sweating, and the anxious facial expression—all signs of the emotion of fear—disappeared upon the bodily recovery and the breaking of the vicious circle. About 95 per cent of the cases of so-called "shell shock" were really emotional shock, and only 5 per cent were due to commotional disturbance produced by proximity to the explosion of a large shell. These were the true shell-shock cases, and if not immediately fatal, they recovered as a rule much more quickly than the emotional case, for the emotion of fear and the unconscious wish to escape from an intolerable situation were not usually a part of their mental attitude as soldiers.

Officers seldom suffered with these hysterical disabilities which were so common in the men; their nervous disability was usually an anxiety neurosis in which the instinct of self-preservation did not play such a dominant part as it did among the rank and file. An exhausted, irritable nervous system, associated with various forms of bodily derangement —e. g., headache, insomnia, tremors, and disorders affecting one or other of the following systems: cardiac, vasomotor, respiratory, digestive, genital, and glandular—was the result of a mental conflict in the conscious and the subconscious mind between two primal instincts—self-preservation and the esteem of the herd. In some the fear of death played the more important part. In others it was an altruistic fear connected with responsibility for the lives of the men under their charge, rather than their own self-preservation, that led to the nervous breakdown. Most of those officers who suffered with an anxiety neurosis were troubled with terrifying dreams of their battle experiences; some suffered with a recurring dream in which they lived over again some horrifying or terrifying experience so vividly that they were afraid to sleep. Some were unable to recall their dreams, but the mental and bodily depression on awakening showed that they had been dreaming of past painful experiences. Many shouted out in their sleep

commands to their men, and a few fought or walked in their sleep. The war has shown the great importance of the subconscious mind; but experience has demonstrated the fallacy of the Freudian doctrine that all dreams with fear are related to forgotten sexual experiences causing a mental trauma. Moreover, it has shown that individual self-preservation and a mental conflict arising from fear, associated with this primal instinct, suppresses sexual desire. It is interesting to recall that Shakespeare, in Mercutio's description of "Queen Mab", refers to soldiers' dreams; and in Lady Percy's speech to Hotspur attention is drawn to the mental conflict in Hotspur's mind and its interference with his marital duties.

But an individual suffering with an anxiety neurosis, which has its origin in the fear that he has irretrievably lost the esteem of his fellows, may arouse through the herd instinct bodily and mental effects similar to those produced by fear for self-preservation. This fact may be explained by the two instincts having been by evolution attuned to a corresponding specific bio-rhythm in respect to fear.

We cannot leave this subject of body and mind without a consideration of the doctrine of Hughlings Jackson's levels. We may consider that there are three evolutional levels in the nervous system, and this hypothesis is supported by comparative anatomy and the effects of functional and organic disease of the nervous system. The lowest level is present in all animals and subserves the primal instincts of self-preservation and preservation of the species. It consists of two parts: (1) the vegetative nervous system, consisting of two systems (a) the involuntary autonomic or parasympathetic, and (b) the sympathetic, with which are associated the ductless glands, and which controls and directs the bodily needs and functions concerned with gratification of the appetites and desires connected with the instincts of self-preservation and propagation; (2) the protopathic sensori-motor nervous system, which controls the reflex activities for protection against pain and injury, including injurious degrees of heat and cold.

The second level is the discriminative sensori-motor level. In the vertebrate series we find two great groups: (1) macrosmatic, in which the nervous structures that are especially developed are those connected with smell and taste; and (2)

microsmatic, in which the senses of sight, hearing, and touch are especially developed. The archicortex of the cerebral hemispheres is highly developed in the former, the neo-cortex in the latter. The projection centers of these senses are around the primary fissures.

The third highest level is the psychic level, in which there is a great development of the cortex of the brain, and which in man far exceeds in development that of the largest anthropoid apes. *Pari passu* with this great development of the cerebral hemispheres is a bodily development far surpassing in excellence all the lower animals: viz., erect posture—by which the forelimbs are no longer used for progression—and perfection of the hand, whereby it becomes not only the instrument, but the instructor of the mind, for, guided by vision, it is enabled to create and make the most varied mental adjustments to environment and control the forces of nature. By the creation of graphic and articulate language, which have simultaneously progressed, has been built up a great social heritage constituting an endowment to civilized man, whose organ of mind is, however, no larger or heavier, and possibly potentially no better, than that of the men who dwelt in caves 50,000 years ago—whose only common mode of expression was, it may be conjectured, mainly by vocal sounds, gestures, and facial expression, a primitive, universal, emotional language understood by all peoples.

Now, in idiots who are incapable of articulate expression and abstract thought, we find only the two lower levels properly represented; the development of the anatomical basis of the psychic level—i. e., the millions of cells in the cortex—is arrested in development and we have a condition, then, of amentia or absence of mind. If we examined sections of the cortex, we should find the supra-granular layer of pyramids especially affected. This layer, as Bolton has shown, is developed later than the infra-granular layer. Moreover, I have shown that as you rise in the zoölogical scale of vertebrates, it is this layer that increases in depth and number of cells.

Simple dementia or loss of mind may be associated with a limited destruction of the anatomical basis of mind—viz., the highest psychic level—and, the two lower levels being more or less intact, the habitual acquired sensori-motor reactions

may remain and the individual then may behave as an automaton in response to environmental influences and bodily needs. Every part of the body is represented in all the three evolutional levels and, as Hughlings Jackson taught, the last to come evolutionally is the first to go. The three physiological levels are functionally interdependent. The highest level, upon which awareness and volition depend, is able to act through the second discriminative sensori-motor level to alterations in the streams of sensation coming from the external world; while the third and lowest level evolutionally is concerned with the involuntary vital functions of the body, and therefore constitutes the basic source of the desires and impulses connected with self-preservation and propagation. I have endeavored in this address to show the inseparability of body and mind, and the importance of the study of biology and bio-chemistry in the study of mind in health and disease.

MENTAL HYGIENE NEEDS ARISING SUBSEQUENT TO SCHOOL LIFE*

C. FLOYD HAVILAND, M.D.
Chairman, New York State Hospital Commission

WHEN an adequate mental-hygiene program for the school period shall have become fully effective, it is certain that there will be a great diminution in the number of mental-hygiene needs arising subsequent to school life. Unfortunately it is needless to say that the school program has barely been undertaken, and the mental-hygiene needs of the adult population remain many and varied. It has been clearly pointed out that if the largest results theoretically possible in the mental-hygiene field are to be obtained, the potential sufferer must be reached in childhood, long before psychotic symptoms develop. Nevertheless, we have as yet, by and large, neglected the opportunity thus presented. The result is that we are left to work on the problem in its vastly more difficult phases, when character and habits have been rather definitely formed. It is the unhappy fact that the majority of individuals who seek aid in the mental clinics that are now carrying on preventive work are individuals who have already made measurable progress on the road to mental disease. This statement does not justify a pessimistic attitude toward the rôle of mental hygiene in the post-school period, but it does indicate the importance of undertaking preventive work to the fullest possible extent in childhood.

The mere extent of the problem of mental disease will ever render it necessary for the state to play the chief rôle in dealing with what is the most menacing of all social dangers. It is a fundamental duty of the state to maintain itself and to afford equal opportunity to its citizens. In formulating and carrying out a mental-hygiene program, it promotes both these ends. It thus accomplishes for the individual what the individual cannot accomplish for himself. Nevertheless,

* Read before the Mental Hygiene Division of the National Conference of Social Work, Providence, Rhode Island, June 24, 1922.

public mental-hygiene activities are not open to the charge of paternalism, so often brought against public-welfare efforts, for the very essence of mental hygiene lies in the proper stimulation of individual initiative and the proper development of personality.

It is unnecessary to emphasize to this audience the fundamental and far-reaching character of the relationship existing between mental disease and defect and all forms of asocial and antisocial tendencies apparent in modern life. We now recognize the futility of attempting to deal with such matters as delinquency, dependency, industrial friction, destructive radicalism, and the like, without taking into account the mental factors involved. We know that distorted or diseased mentalities are responsible for a large proportion of such unhealthy social developments, and we also know what can and should be done about it. If we possessed ideal facilities for the identification and treatment of mental disease in its incipiency, there is every justification for the belief that it would be revealed as increasingly susceptible of control and correction, with a consequent alleviation of the related social ills that have heretofore largely resisted successful management and that so often threaten the welfare and even the security of society.

Equal opportunity does not mean similar opportunity. It does mean an equal chance for successful social adaptation. But as capacities, both intellectual and temperamental, vary within wide limits, social and economic demands must be relatively commensurate with capacity if there is to be successful adjustment of individuals to environment with actual equality of opportunity. It is to such an end that mental hygiene addresses itself. There is thus no activity of a state more potent for good, more important for the individual or the state itself, than an adequately conceived and successfully executed program for mental hygiene. The promotion of mental health, the prevention of mental disease, and the provision of adequate treatment for mental disease, especially in its incipiency, promise not only more for human happiness, but more for human efficiency than any other mode of attack upon the ills of organized society.

An ideal program for mental hygiene thus comprises a far

larger field, not only for the school period, but for the post-school period, than any state has yet deemed it practicable to cover. However, certain states in recent years have made measurable progress in extending the scope of their mental-hygiene activities, especially in the matter of the treatment of mental disease. But possibilities will not be fully realized until there is general appreciation of the fact that prevention is greater than cure in the realm of mental disorder, just as in that of physical disease. And important as are preventive measures in childhood, they are of equal importance in later life, when the individual encounters an ever-increasing number of upsetting strains and stresses, presented by the most complex social structure ever yet evolved. Thus progress in mental hygiene may be measured by the growth of facilities for the prevention of mental disorders, no less than by the development of facilities for the treatment of mental disease.

But as is usually the case in movements to promote social welfare, theory in mental hygiene has outstripped practice. No state has fully met the immediate and obvious duty of providing adequate facilities for the care and treatment of those cases of extreme mental disorder designated by the legal profession as insane. No state has yet been able to do so, for the excellent reason that as modern facilities have increased, the number of known insane has increased—needs have continued greater than the facilities for meeting them. In all parts of the country there has been a constant parallelism between improved and increased facilities and the number of cases seeking treatment. It thus seems a fair deduction that the increase of known insane is, in part at least, due to increased confidence on the part of the public in public institutions—that a certain number of mental cases are not revealed in public records when public institutions render inadequate service.

The rather general increase throughout the country during the past two or three years in the number of mental patients under treatment in state hospitals demands the serious attention of all those interested in public welfare. For example, the net increase of patients on the books of the New York state hospitals, for the fiscal year ended June 30, 1921, was 1,442, the greatest increase of any year in the history of the

state-hospital system. While the rate of increase during the current year is somewhat less, it now appears that the net increase will approximate 1,200 for the year ending June 30, 1922. The cause of this increase is now the subject of a careful investigation by the New York State Hospital Commission, and while it is impossible at the present time to evaluate properly all the factors involved, there is reason to believe it is in large measure the reflection of economic conditions. Not only do periods of financial stress result in undue mental and nervous strain, producing mental disease in unstable individuals who might otherwise successfully cope with social demands, but they cause families and relatives of disabled persons to seek financial relief by throwing the burden of care upon the state, when in normal times they assume it by keeping patients in the home or in private institutions.

It is the obvious duty of a state to continue state-hospital construction to the point of providing bed capacity and treatment facilities fully commensurate with the need for them. In New York such a construction program is now in process of execution; approximately 1,400 additional beds will be available during the present year and approximately the same number next year. Present plans contemplate the provision of additional bed capacity each succeeding year until the present distressing overcrowding in the New York state hospitals, with its obvious evils, will be a thing of the past.

Aside from the provision of adequate bed capacity, hospital development must be considered incomplete until adequate living accommodations are provided for physicians, nurses, and attendants. Special equipment is valuable and necessary for successful treatment, but no equipment equals in importance properly trained, high-grade personnel. There is no substitute for kindly, sympathetic, tactful, and understanding human relationships, and the type of person the hospitals need can be retained in their service only as living conditions are provided that will approximate those obtainable outside.

In view of the urgent necessity of relieving the overcrowding that prevails in practically all parts of the country, it is absurd to think that patients are improperly detained in modern state hospitals, as is sometimes charged by the uninformed and ignorant. Most states have adopted a liberal parole

policy, which clearly shows that state hospitals are making every effort to restore patients to society as soon as is consistent with the welfare both of patient and of society. With a census of 42,400 patients on the books of the thirteen civil and two criminal state hospitals for mental disease in New York, over 3,200 patients are on parole. The number of patients on parole from the civil state hospitals has increased by nearly 1,700 during the past five years. The fact is that there is far more danger that a mental patient may fail to receive the indicated hospital care and treatment than there is that he will be improperly detained.

While treatment in a state hospital implies deprivation of liberty and hence the necessity of a legal process, it is to the interest both of individual and of state to make facilities for treatment readily available with as little legal hindrance as possible. The fear of illegal commitment is a heritage of the past and is based on false conceptions. While occasionally a technically sane person may be committed—such as a drug habitué, a defective without psychosis, or a dotard—it may be asserted that, under the enlightened laws now operative in many states, no person in a normal mental condition can be committed to a state hospital. The laws of New York respecting the admission of patients to hospitals are examples of these more enlightened statutes. They provide for the immediate or so-called emergency admission of patients certified by qualified medical examiners to be in need of immediate treatment, thus obviating delay when, as is still the case in many small and some large communities, suitable facilities are lacking for the care of patients pending commitment. There is also provision for admission on voluntary application when, in a superintendent's judgment, a patient's mental condition is such as to allow him to understand the nature of his act, but also such as to warrant treatment in a state hospital.

The operation of the voluntary-admission law has had a most salutary effect in emphasizing the hospital idea in contradistinction to the old "asylum idea", with its evil connotation. During the year ended June 30, 1921, 5.1 per cent of all admissions to the New York state hospitals were of the voluntary class, a percentage that has remained practically

constant during recent years, but only because of lack of facilities for the care of a larger number. There is no doubt that a state can well afford to encourage such admissions in greater numbers when accommodations render it possible to do so. It is thus possible to bring under treatment, at a time when treatment is of most avail, the border-line psychoneurotic cases, from whose ranks more frank psychotic cases come. There are private hospitals for mental disease with from 50 to 60 per cent of admissions on a voluntary basis, and while the demands on public institutions are such that it will probably never be possible for them to receive such a percentage of voluntary patients, it is wise state policy to render treatment facilities readily available to incipient cases. Recoveries are always in exact ratio to the promptness with which treatment is instituted.

Our modern state hospitals are hospitals in fact as well as in name, equipped as they are to deal not only with all types of mental disease, but with all forms of physical disease. Chief emphasis will ever be laid upon their curative efforts. But after all not more than 20 to 25 per cent of an average admission group is as yet recoverable, despite the application of our best knowledge and skill. That means there is an ever-increasing number of so-called chronic cases of mental disease in our institutions whose maintenance constitutes a tremendous financial burden. In the future development of hospital work, more effort should be directed toward securing such partial rehabilitation of the chronic deteriorated patients as may be possible. It is in this connection that the extension and further development of occupational therapy will find a great field of usefulness. Occupation for mental patients is not new, but it has heretofore been largely confined to patients who occupied themselves voluntarily. But now our chief concern is the idle and often disturbed and untidy chronic patients, with whom intensive and prolonged effort is necessary to secure results. But such results, when secured, are worth every possible effort. Through occupational therapy, habit training, and reëducation by means of simple kindergarten methods, there are relatively few chronic patients who cannot be trained to some useful activity and thus rendered able to fill a niche, however small, in the hospital organization.

The chronic wards of the future should be practically deserted after the household work has been done, as the patients go to the simple duties for which they have been trained. Occupational therapy of such an intensive character requires a considerable initial expense, but it is ultimately an economy, through the elimination of destructive tendencies and the transformation of patients from total liabilities to at least partial economic assets.

The bulk of chronic patients suffer from that form of mental disease known as dementia praecox, in which there are varying degrees of deterioration, but usually a final arrest of the deteriorating process on a lowered mental plane. Such patients, when trained to useful activity within the bounds of their diminished capacity, are comparable to defective persons similarly trained. Just as the latter now lead happy and relatively useful lives in industrial colonies, both in institutions and in the community, so may the industrially trained chronic mental patients become less of a burden in the small farm colonies that are becoming a feature of our state hospitals and that will be multiplied as the possibilities of occupational therapy are realized and means permit. It may even be possible to profit by the experience of our *confrères* in the establishment of industrial colonies for defectives in the community, as it would seem well within the bounds of possibility for such a colony of selected chronic mental patients to function successfully.

However well organized and equipped a hospital may be for the modern treatment of mental disease, it is to-day generally recognized that its extramural activities are fully as important as its intramural work. The isolated mental hospital, especially if mere custody be its chief function, is an anachronism. The present-day hospital must be a center from which radiates information on all matters pertaining to the maintenance of mental health as well as to the treatment and disposition of persons mentally diseased. It must reach out into the community in an effort to prevent mental disease and to secure the reëstablishment of paroled and discharged patients. To its primary function of treating mental disease must be added the function of preventing mental disease. The agency through which such work is accomplished is the

hospital mental clinic, with its associated social-service department. Primarily established to promote the parole of patients, mental clinics are now able to do considerable preventive work, attracting as they do not only potential mental cases, but friends and relatives of such cases. During the last hospital year, the forty mental clinics maintained by the New York state-hospital system were attended by over 13,000 persons, over 4,600 of whom had never been in a hospital.

Theoretically, clinic work should reduce the number of admissions to state hospitals, but, as already indicated, such a result has not yet followed. The explanation in part would seem to be that there are many more psychoneurotic borderline cases in the community than was previously supposed. Heretofore not susceptible to statistical treatment, such persons have not been identified as a group. Although a considerable proportion of them never develop a frank psychosis, there results from their mental disability an incalculable wastage of human energy and productiveness, not to mention the load of misery and unhappiness proceeding from ill adjusted, unbalanced lives. As a matter of fact, there are few normal persons who cannot profit from a knowledge of mental hygiene, which teaches self-knowledge and enables the individual to recognize and successfully deal with unprofitable and hampering mental habits and attitudes. Mental hygiene enables the normal individual to approximate more closely his potential possibilities and capacities than he otherwise could, and there are few persons who fail to realize that they do not attain the height of their possibilities. There is thus a mental-hygiene service to be rendered the entire community. We cannot too soon abandon the idea that mental-hygiene needs are confined to the mentally diseased or the mentally disordered.

Thus, even if mental clinics have as yet failed to reduce the number of patients admitted to the state hospitals, they perform an essential function which it is wise state policy to foster. To meet the needs of rural and small communities, some of the clinics may well be of a mobile character. Ready means of relief will thus be at hand for all those who need it, and preventive work on a state-wide basis can be undertaken. While primarily diagnostic and advisory centers, the

clinics should provide treatment for those who would not otherwise receive it, although, when possible, it seems desirable to make use of local psychiatric personnel and facilities in conjunction with those of the state. Local assistance and participation stimulate local interest, and local interest promotes permanency.

Just how many clinics are required to serve a given community is still uncertain, for as a rule the greatest difficulty experienced by the clinics already established has resulted from the unexpected numbers that seek aid and advice. In New York in no instance has a clinic been discontinued because of lack of patients. The problem has been rather how, with the relatively limited personnel and facilities available, to serve adequately all those who attend the clinics.

The success attending the campaign against tuberculosis has been largely due to the dissemination of information that has greatly altered the public attitude regarding this disease. It is no longer "the white plague", but a disease that can be and is being controlled to an extent deemed impossible but a few years ago. In the same way, dissemination of information as to healthy mental habits, the nature and danger of unhealthy ones, the perilous factors in an individual's environment and social relationships, will serve to rob mental disease of much of its mystery and terror and will induce a common-sense attitude toward it, akin to that now manifested toward the physical diseases that are yielding to public-health efforts. When such a common-sense attitude becomes generally prevalent, and only then, will mental disability lose much of its present power for evil. Hence, mental clinics have an important educational function. If the average individual could be made to realize that any radical change in a person's usual conduct, especially if abrupt and without assignable cause, may be indicative of mental disease, it is certain that many mental disorders could be avoided. But more often the onset of mental disorder is gradual and insidious, and so efforts must be made to inculcate the idea that any person who finds difficulty in self-guidance and in meeting the demands of daily life may be at least a potential sufferer from mental disease and one who can profit from skilled psychiatric attention.

No mental clinic can properly function without a trained psychiatric social service, which is perhaps the most important agency of all in spreading a knowledge of personal mental hygiene. The treatment of mental disease implies treatment of the social situation in which the disease appears and for which it may be in large part responsible. Thus the best results can follow only as means are available of gathering facts relating to home conditions, working conditions, amusements, and the predominant interests of the patient. Advice to a patient's family as to the attitude that should be assumed toward him not infrequently does more good than advice to the patient. Thus psychiatric social service is essential in any mental-hygiene program. Social service in general would have been the recipient of much less unfavorable criticism if social workers had had more psychiatric training, teaching them, as it does, how to recognize and successfully deal with all sorts of personal types.

While state hospitals should be and are prepared to treat all types of mental diseases, of which it should be remembered there are many, the majority of communities are at a considerable distance from these hospitals, and there remains a large field of usefulness in the principal centers of population for the so-called psychopathic hospital, conducted on the same basis as a general hospital, for the immediate active treatment of acute mental disorders. Where such institutions have been established, it has been found that it is possible to discharge without commitment the majority of patients who seek treatment, thus affording direct relief to the state hospitals. For instance, the Boston Psychopathic Hospital finds it necessary to commit less than one-half of the patients admitted. No type of institution does more to destroy the old fatalistic attitude toward mental disease than the psychopathic hospital. It demonstrates in a direct way by the results obtained that active treatment in the early stages of numerous types of mental diseases is effective. It teaches that a mental disability is to be regarded in exactly the same light as a physical disability—that the one is as much a disease as the other. It serves an important educational end, particularly in rendering available to the medical profession educational facilities in psychiatry comparable to those now existing in

other less important medical specialties. Psychopathic hospitals should, therefore, constitute a major feature of any general mental-hygiene program.

Practical considerations will ever restrict psychopathic hospitals to large centers of population, preferably in close relationship to medical colleges. In the smaller cities, psychopathic wards in general hospitals should be established to meet the same need as psychopathic hospitals in the larger communities. Local hospital authorities are apt to think that such wards exert a disrupting influence, notwithstanding the evidence to the contrary furnished by Pavilion F of the Albany General Hospital, which has for years served as a psychopathic ward, not only without hampering the other work of the hospital, but greatly aiding it. It should be the policy of a state to urge such wards in all general hospitals that can furnish suitable facilities. A lack of trained psychiatric personnel in many places will undeniably prove an obstacle, but if public opinion demanded it, the lack would be overcome. It is through the cultivation of such public opinion that mental-hygienists may properly seek the establishment of psychopathic wards in general hospitals.

It is evident from the foregoing that if a mental-hygiene program is to be effective, it must take on the character of a public-health movement, which, of course, it is. We have too long been obsessed with the idea that mind and body were distinct entities, to be treated separately. Happily, such an erroneous conception is fast becoming obsolete. A human being is a psycho-biological unit in which psychic and physical elements are interdependent, reacting one upon the other, with what we recognize as personality as the result. Health implies harmonious adjustment, both physical and mental, and hence no public-health movement is complete that fails to embody provisions for meeting the mental-hygiene needs of the community.

To recapitulate:

While preventive mental-hygiene work has its largest opportunity in childhood, mental-hygiene needs subsequent to school life are many, varied, and of the utmost importance.

The extent of the problem of mental disease renders it necessary for the state to play the chief rôle in dealing with it.

In formulating and executing a mental-hygiene program, the state promotes its own security and provides actual equality of opportunity for the individual.

The most obvious duty of a state in relation to mental hygiene is to provide proper and adequate facilities for the treatment of such cases of mental disease as are legally termed insane.

No state has yet been able to provide such facilities, owing to the increase of known insane.

The increase of insanity is, in part at least, more apparent than real, although depressed economic conditions are probably responsible for some actual increase.

Modern state hospitals for mental disease have developed parole systems whereby patients may return to the community under continued supervision. Community contact is increased through provisions for voluntary admissions, while provisions for emergency admissions are necessary, especially where proper facilities are lacking for the care of patients pending commitment.

State hospitals must be essentially curative institutions, although they have a function to serve in the partial rehabilitation of chronic mental patients. Reëducation of such patients through occupational therapy must be greatly extended, if hospitals are to reach their limit of service.

Institutions for mental disease must emphasize extramural activities no less than intramural ones, to the end that mental disease may be prevented and paroled and discharged patients may be reëstablished in society.

It is just as important to provide special facilities for the treatment of incipient mental disease as it is to provide means of treatment for the so-called insane.

Such facilities include out-patient mental clinics with associated psychiatric social-service departments, psychopathic hospitals on the same basis as general hospitals, and psychopathic wards in general hospitals in small communities.

No public-health movement can be regarded as complete that fails to meet the mental-hygiene needs of the community.

PSYCHOLOGY IN MEDICINE*

F. L. WELLS, PH.D.
Boston Psychopathic Hospital

LIKE some nations, psychology has in the past suffered from very artificial frontiers. Nor is it wise to define too exactly the boundaries of one's science. We are approaching a rather satisfactory conception. It is to regard as the subject matter of psychology those processes by which the organism reacts as a whole to the environment or to its own conditions. This may denote a broader field than previous attempts at definition, but it also implies more natural boundaries. The ambitious name of psycho-physics, for example, attached itself to a problem on the relation of stimulus and sensation which has a minor rôle in the psychology of to-day. Similarly, "personal equation" was spoken of as if it were bound up with the simple reaction time. One might recognize psychological sciences in somewhat the same way as physical sciences. Sociology and anthropology are such psychological sciences. So are the "science of human behavior" and the experimental psychology of university development, as well as comparative psychology. Psychological sciences are a natural division of biological sciences.

Psychology in one of its restricted senses is the science of the behavior of those who make up our social order. For the practical purposes for which it holds itself responsible, it distinguishes good and bad behavior according to the nature of the adaptation to the surroundings. Psychology has a legitimate interest in understanding anything that brings such conduct about. Any discipline concerned with the proper control of human conduct has a legitimate, not to say a responsible, interest in psychology.

* Read by title at the Seventy-eighth Annual Meeting of the American Psychiatric Association, Quebec, June 8, 1922. Published simultaneously in the *American Journal of Psychiatry*.

Medicine has long acknowledged and assumed responsibility for the behavior of most bodily processes as such. Disordered behavior of the organism as a whole has had relative difficulty in recognition as a medical function. This was a natural expression of the medieval dualism of body and spirit. "More needs she the divine than the physician", is the view of Lady Macbeth's much quoted medical advisor. The so-called insanities, the most socially disturbing types of behavior disorder, have been coming under medical supervision for upwards of a century. Medical supervision of feeblemindedness, and to some extent of criminality, characterizes certain advanced communities. It is difficult to shut one's eyes to the evidences of a broad current setting toward medical responsibility for the behavior, not only of the liver and pancreas, but of the organism as a whole.

But owing to the same medieval dualism of body and spirit, it came about that psychology, the discipline most directly concerned with the functioning of the organism as a whole, or the mind—whichever you prefer to call it—developed not as one of the sciences of medicine, but as a parthenogenetic offspring of the conventional mother of sciences, philosophy. Psychology thus acquired a stronger "mother fixation" than physics, chemistry, or astronomy. Only recently has it achieved a generally acknowledged place in the family of natural sciences. Its dissociation from medicine has been comparable to that of geology. The facts would justify a situation more like that with regard to chemistry. Chemistry denotes a field of knowledge perhaps no broader than psychology, though far more developed. Medicine teaches, and contributes largely to advance, that portion which is most relevant to medicine. Assimilation of psychology has been far less ready than in the case of chemistry, though there are branches of psychology of similar significance to psychiatric problems. The result is that non-medical persons may be confronted with medical problems on a relatively modest basis of medical equipment, and medical workers are asked to meet psychiatric problems with an important part of this equipment unsupplied. This is not to the interest of science, practitioner, or patient.

One should get over the practice of dissociating psychologist

and physician as if they were something mutually exclusive. There have always been and there always will be as good psychologists in the medical profession as out of it. Both psychology and medicine will be better off if a time comes when the term psychologist connotes physician not less nor more than does the term physiologist. This cannot be for years; things have moved too long and too far in a different direction. There is a group of us, not without group consciousness, whose business it is to meet certain problems that ought to be medical and unfortunately sometimes are. These problems were perhaps discovered by medicine, in the sense that America was discovered by the Vikings. But progress toward their solution has been very much the work of non-medical psychologists. The present dissociation is a logical result of the history of the two disciplines. I am doubtful whether it should be a permanent situation. If the attitude of medicine gave no prospect of a reasonable assimilation of psychology, then one could perhaps justify an effort to build up a discipline—not now existing—to enable psychology to do the best that could be done without medical affiliations. It was in this light that the matter at first presented itself to me. But when either path is open, as now seems certainly the case, it is well that psychology should weigh the issues very carefully before committing itself to an introversive development.

Medicine has "sold" itself psychology principally on the basis of the intelligence scales. Now there is a very human tendency to overlook the complications of a method none too well understood, when its results are expressed in plus or minus signs or a simple numerical term. So we are told that the only use of statistics is to refute other statistics. There is no doubt that the simple, global figure of an I. Q. often tells the data-hungry clinician somewhat more than it should. The psychologist cannot throw many stones here. But the uncritical use of psychometric methods in medicine is only less unfortunate than the ignoring of them altogether.

Desirous as one may be for the entrance of psychology into the family of medical sciences, one hardly wishes to see her do so as a poor relation. Out of this has probably come the feeling that a doctoral level only should be officially recog-

nized. Such recognition implies that one is competent to represent the psychological aspect of a problem in cases in which the authority for synthesis is with medicine, or to assume the authority for synthesis when it lies within psychology, as it might well do with an educational problem.

At this point one encounters a dislocation between psychology and psychologists. Psychology includes certain conceptions that have arisen under the influence of psychoanalysis, and with which non-medical psychology has had comparatively little to do. These conceptions did not develop as a part of the traditional psychology, nor has it found them very assimilable. As we know, these formulations are exceedingly speculative, but their serviceableness has been such that they deserve to form a part in every psychological system organized on inclusive lines. Their character is such that they could not well have originated outside a medical setting. There is hardly a motive other than the desire to be relieved from suffering that will lead to divulgence of the emotionally highly charged topics that are woven into the structure of psychoanalysis. There are non-medical psychologists who do very creditable psychoanalytic work, but without a closer contact between psychology and medicine than has yet been attained, the material of psychoanalysis will remain largely outside the scope and control of scientific psychology. Psychiatrists in general, and our own elder statesmen, are probably ready to agree that psychoanalytic work, like hypnotism, involves risks to operator and subject that should be most reluctantly undertaken outside the setting of responsibility that medicine traditionally provides.

The place of psychoanalysis in psychiatry is for the medical man to regulate. Something might be said, however, with regard to its position among psychologists. Extreme opposition to it seems rarer than among physicians. Probably most of us believe that it is a useful art. A few of us, while far from committed to its teachings as such, prize it highly for a depth of view that it has aided us to achieve. In point of scientific evolution, few, if any, of us, regard it as having passed, or as now engaged in passing, beyond the observational or "bug-hunting" stage. Its popular vogue is based mainly on the sanction it offers to erotic talk and ruminations.

Ideally, it is to experimental psychology something what the good hospital is to the good school. One renders essential service to acute individual needs; the other performs a broader and in the aggregate a greater service, if one of less imaginative appeal. To people who are in need of its services, psychoanalysis is worth more than psychometrics. For society in general, it is doubtful if the entire structure of psychoanalysis is worth as much as the principal intelligence tests. This side of the shield is held up here because psychoanalytic writers sometimes base their comparisons of the two fields essentially on their pathological relations. For such a purpose one should take a broader view than is bounded by a consulting room and a library. The influence of experimental psychology in the matter of the direction of human conduct is both the greater and the more rapidly extending.

With regard to the exercise by psychologists of public functions, especially as concerns the commitment of feebleminded persons, it is hard to bring oneself to believe that any non-medical person should assume full responsibility for such commitment. Every case of mental defect is potentially a medical problem. Medical education and responsibility should always be represented in such cases. It seems equally proper, however, that there should also be represented in such councils the type of experience embodied in the American Psychological Association's Section of Clinical Psychology, experience which a committing physician has not always had the opportunity to acquire. A law to the effect that one of the committing officers must have psychological training of this level might well be advantageous in states like New York, where this type of expert knowledge is relatively available.

There is room for some solicitude about public protection against those who consider themselves psychologists seemingly with rather moderate insight into the limitations of their scientific equipment. But, as in similar situations in other fields, the fundamental remedy lies with the public itself. It is proper to ask of scientific psychology that it formulate adequate standards and make services governed by such standards reasonably available. The regulation of consulting psychologists by the general association, and the Psycho-

logical Corporation, are moves in this direction. The ultimate responsibility for public protection rests with the public.

The doctor of philosophical setting of psychology attaches special interest to codes that bring this issue into the laws regulating the practice of medicine. The issue is rich in casuistry. At least it is better to have people surprised that you haven't an M.D. than that you have. The assumption that a doctoral individual working in a clinical setting must be an M.D. is so deep-rooted that the most conscientious of us fall easily into a rôle of *medecin malgré lui.*

Beyond the avoidance of wilful deception, it would seem that the responsibility for this distinction could rest with society. It is but academic accident that has thus classified us as doctors with physicians, divines, osteopaths, veterinarians, and philanthropists, rather than with lawyers and engineers as plain mister, or as professors with philologers. and tattoo artists. That it makes their work more effective is fair reason for applying the doctorate, in a medical sense, to persons who are candidates for the medical degree, and only the extremest among physicians asks for its discontinuance by psychologists. More real objection is not against the designation of doctor, but against the vagueness of this designation. A Ph.D. is no evidence of any training in the psychology with real medical contacts.

We are at a rather critical stage in the development of medico-psychological relationships. The next few years will weigh heavily in determining whether clinical psychology shall give rise to an independent group in quasi-rivalry with the physicians, or find a dominion status in the family of medical sciences. The former event would seem a precipitation rather than a solution—a regression indeed. Perhaps one sees most broadly when one focuses at a distance and looks beyond personalities to the terms of psychology and medicine. Surely it will be best for both when each learns with the most freedom from the other. In general the gains of science are the gains of the workers in that science as well as of society.

The failure of sciences with so much in common as psychology and medicine to amalgamate would not be a reassuring symptom among the complicated conditions that society

faces to-day. Medicine is the greatest human discipline under scientific domination; psychology is the organized study of human behavior; both are members of a house that should not be divided against itself. Science itself has yet to be "sold" to humanity. Perhaps the average man has an inherent preference for social control by hurrah. He is at least entitled to a fair choice. It is not a new sentiment that the future of civilization rests upon the taking of the helm by science, where politicians fail and even the older religions seem to be losing hold. One of its best expressions came, in calmer days than these, from an early work of the man who has made famous the name more obscurely carried by the present writer. Is it not interesting, by the way, that H. G. Wells published in his early days vision after vision of the future, and spends his later ones in compiling a survey of the past? As far back as 1900, his psycho-physician of centuries hence admonished the wreck of a decadent captain of industry in these terms:

> "You see . . . from one point of view people with imaginations and passions like yours have to go—they have to go . . . Die out. It's an eddy . . . We get on with research, you know, we give advice when other people have the sense to ask for it. And we bide our time . . . We know enough now to know we don't know enough yet. But the time is coming, all the same. *You* won't see the time. But between ourselves, you rich men and party bosses, with your natural play of the passions and patriotism and religion and so forth, have made rather a mess of things, haven't you? Some of us have a sort of fancy that in time we may know enough to take over a little more than the ventilation and the drains. Knowledge keeps on piling up, you know. And there's not the slightest hurry for a generation or so. Some day—some day men will live in a different way."

As to the bearing of such a homily on our own problems, the support of psychology belongs to any group of sciences according as it is able to carry scientific discipline into the affairs of men. As such, not a little share of our science belongs to medicine. As to the technique of infiltrating psychology into medical education, opinion inclines to premedical training for the general practitioner and graduate training for the specialist. The part that psychology has in industry would seem assimilable into the medical developments in industrial hygiene.

Thus the most hopeful outlook seems to be toward a fusion

of medical and psychological sciences into the best equipment for handling the adjustment problems of the human organism as a whole. Medicine and psychology together are a large order, and of course there are limits to the training the human mind can or should assimilate. Specialization is a partial answer, and another is the truism that it is not how much you know, but what you know and how you use it. It has been done before, "and then some", by an intellectual mastodon among our colleagues who dwelt in the seclusion of a small Middle-Western college some fifty years ago. We all remember the courtesy of the famous jurist who gave his seat to three women. This colleague of ours held the seat of learning for as many professors. To support the bulk of his vast and single intellect, his institution accorded him the chairs of "phrenology, penmanship, and hygiene".

THE IMPORTANCE OF A SPECIAL EDUCATIONAL TRAINING FOR MENTAL DEFECT DEPENDENT UPON ORGANIC LESIONS

L. PIERCE CLARK, M.D.
New York City

ONE would naturally infer that our knowledge of any particular nervous disorder would be materially advanced if two or more groups of special investigators approached the same problem, but this does not often hold true. Teamwork in medical research in this country is perhaps not so well organized as in some other branches of science, and these border-land studies and publications are somewhat better handled abroad. My remarks apply particularly to the advancement of our knowledge of mental defect.

Intelligent laymen would infer that inasmuch as the teacher, the psychologist (psychometrists for the most part), and the physician or psychiatrist (psychasthenists) are mutually interested in the problem of the feebleminded, the subject could not be better supported than on this tripod of investigation and that research would receive a triple impetus from such combined effort. But progress in the fundamental principles of education for children has made no material advance since the time of Froebel and Pestalozzi,[1] while education of the feebleminded child in particular is still slavishly following the "intellectualization of the senses" of the elder Séguin. Until very recently, psychometrists have been largely engrossed in more accurately enumerating the various intellectual defects of the obviously feebleminded child and have perhaps contributed no one really constructive program for solving the problem of the betterment of this class. The specially trained psychiatrist—the psychasthenist—has outlined no real advance either in classification or in specific diagnosis. So the field of psychasthenia remains almost

1 Personal communication from Dr. Buck, Director, Geneseo State Normal College.

virgin soil for scientific exploration. No great advancement has been made in years, aside from the detection of the specificity of thyroid feeding in hypothyroidal states and cretinoid idiocy.

Why have we been marking time in this field of neuropsychiatry? Perhaps it is because it is one of the most difficult of all problems. From Goddard's data, although the validity of his evidence has recently fallen into disrepute, it would seem that a few years ago the genetic view of feeblemindedness purely as a hereditary causation could be accepted.[1] The experimental work of Stockard on animals, however,[2] and the biologic work of Davenport on the eugenics of family studies tend to discredit the purely genetic view of feeblemindedness and to prove that it must be seriously modified as the basis for even a tentative program. In point of fact, various accidental factors of imperfect development of germ plasm either before or after conception (Davenport), the exogenous factors or modifiers of the rates of development of the embryo and fetus (Stockard), the endocrine and toxic factors during gestation, both in the mother and the child, which later are expressed in mental defect (Weygandt), must give us pause in the evaluation of the genetic view that has been until recently held valid. The crying demand is for a department of research upon the broadest psycho-biologic lines, directed by one who will be able to coördinate all the special fields of research and assign them their proper places in this pressing problem.

1. There is need for better clinical departments in all institutions for feebleminded persons, the same to be conducted by trained psychiatrists supplemented by psychologists and lay assistants, the problem being medical, psychological, and educational.

2. There should be laboratories for clinico-pathological research. Associated with these laboratories there should be

[1] See *A Contribution to the Etiology of Feeblemindedness, with Special Reference to Prenatal Enamel Defects*, by L. Pierce Clark and Charles E. Atwood. *New York Medical Journal*, May 17, 1922, Vol. 115, pp. 543-79.

[2] See *Developmental Rate and Structural Expression*, by Charles R. Stockard. *American Journal of Anatomy*, January, 1921, Vol. 28, pp. 115–277. See also Stockard's discussion of Clark-Atwood paper. *New York Medical Journal*, May 17, 1922, p. 647.

an experimental and biologic station where control chemic and metabolic studies could be made.

3. The cost of caring for approximately 42,000 mental patients in public institutions and under private care in New York State was about 15 per cent of the total cost of the state's expenditures in 1920. Impressed by the magnitude of this problem, the state several years ago established a psychiatric institute, at an annual expense of approximately $50,000, for purposes of research into the causes and methods of prevention of mental disease. The number of feebleminded persons in the state institutions and at large is estimated at 45,000, thus showing feeblemindedness to be a problem as great as that of mental disorders (insanity). Yet there is practically no appropriation made either publicly or privately for any similar research into the cause and prevention of feeblemindedness. Until something of this sort is undertaken, we shall be swamped with theoretical matter and one-sided views of the etiology of feeblemindedness.

The practical part of my paper lies, however, in another division of this subject—namely, the lack of proper classification of the various accidental instances of feeblemindedness that are assembled for training treatment with those which we call the purely genetic or hereditary types. One would suppose that a difference in treatment of these two types would be axiomatic, but it is not; one is continually confronted with instances in which no difference in educational training is being made. In many neurologic discussions one hears the distinctly opposite view defended. An equally absurd position might be taken, for instance, that it is possible for us to make mental measurements of a large group of dementia-praecox patients and show from them that dementia praecox is preponderantly an issue of mental defect; but common sense and clinical experience prove this to be a fallacy in regard both to the nature and the treatment of this functional mental disorder. Perhaps we can make our point of most practical value by citing several cases in which the mere designation of mental defect in children was not sufficiently specific for a system of training treatment; and if such designation had been followed into a final disposal of the case, our plan of

mental training would have fallen short or have miscarried so grossly as to be of lasting detriment to the child.

Case 1 is that of a six-year-old girl suffering from what I have designated as cerebro-cerebellar diplegia. The case has been reported in detail in a paper published elsewhere.[1] At four and one-half years, it was noted that she had the repellent leer of a low-grade mental defective. She was speechless. Tests showed that the greater part of her apparent mental deficiency was overlaid by the motor defects. Instead of being sent to an institution for defectives, she was placed with private tutors under a system of training treatment especially adapted to overcoming her fearful handicaps. The principles upon which this training was based have also been thoroughly detailed in my report. The important result and most noteworthy fact to be mentioned here is that after a training of several years (she is now twelve years old) she has begun to attend common school and is nearly up to grade in classwork; she shows an almost uncanny genius for mechanical work and bids fair to excel in some artisan occupation.

Case 2 is that of a girl now fourteen years old. She, too, was reported in my series of cerebro-cerebellar diplegics. Her mentality, seemingly in greater part due to the definite nerve lesion, was four or five years retarded. She was placed in an institution for mentally defective persons for several years and was given the routine training, under which she did poorly. Efforts to explain the special nature of the mental defect—that it was conditioned in greater part upon the organic lesions induced at birth—were unavailing. She was then removed from the institutional system and placed under private and special tutors and with normal associates. As a result of this special and freer system of educational training, adapted to her unique type of neural and mental disorder, her progress in mental development has doubled.

Case 3 is that of a boy now eight years old. When first seen, at three years of age, he was a low-grade idiot, impossible of control or direction. His mental state was apparently secondary to a meningitis. The meningitis in turn was secondary to a double inhalation pneumonia from a severe chronic colitis at eighteen months of age. The boy was essentially normally endowed at birth, but had an acquired mental defect. He was placed in one of the best institutional schools for mentally defective patients for two years, but aside from improvement in conduct, he obtained little mental advancement. The school was apparently not willing or able to modify the educational training treatment of the ordinary so-called feebleminded child to meet the needs of this special case. When he first came under my observation, he could not express a want, depending on others to provide for him. He knew nothing at all about dressing himself and could not tell one garment from another. He spent his time roaming aimlessly about, usually holding on to some round object, such as a stick.

For the past two years he has been under private tutelage and training and has made remarkable strides in mental development. First we attended to his physical repair, for he was suffering from a severe colitis and had

[1] *Congenital Cerebro-Cerebellar Diplegics, with Notes upon Their Training Treatment.* *Medical Record*, May 5, 1917, Vol. 91, p. 755.

many stools each day. He gained in strength and became more physically active and it was then possible to give him mental and speech training. At first it was almost impossible to gain his attention for more than a few seconds at a time. He became cross and petulant under direction, and the work was necessarily slow. However, it was possible to add little mental drills each day until at last it became noticeable that he was beginning to pick up new words. First he expressed his wants by uttering one word; by carefully having him repeat little phrases that explained what his one word indicated, it was possible to get him to retain many words and phrases until he is now able to make up spontaneously short sentences. He understands any request, appears to have a rather remarkable memory as to where various articles are kept, and can procure them at short notice. He is becoming more and more spontaneous in his actions, and perhaps the best example of his progress is his ability to comprehend everything. He knows all the articles of his clothing, and aside from a slight deformity of the index finger of each hand which prevents him from being able to use these fingers in buttoning, he is able to dress and undress himself. At present he enjoys the best of physical health, is happy and contented, and shows more ability to create his own amusements.

From the foregoing illustrative instances, it would seem that there is a fairly large number of cases of truly accidental mental defects in which the antecedent fault of nervous lesion is overlooked or neglected in the educational training. In many such cases, the lesion may possibly be negligible in its impairment of the function of the brain as an organ of the mind, but not to take account of this partial impairment is to miss the point of the educational training treatment. Obviously, the undamaged structures are quite capable of undertaking the same or similar training as in one not so handicapped. If, on the contrary, the inheritance is much tainted, the possibilities for development even in mildly damaged brains are poor. We must be careful to apportion to each factor its proper rôle in the hindrance of development, and though the child appear very stupid, we should remember that surprising improvement may be expected in all children suffering from brain injury incurred at birth or in early life—exclusive of those suffering from hemiplegia with or without epilepsy. In this latter respect a double palsy or diplegia is much more hopeful in after-development than a strictly unilateral palsy. A part of the training is, of course, to be directed to overcoming or minimizing the structural defect in the brain, while the maximum effort in education should be but a modification of the so-called common-school methods. A matter of extreme importance for these children with

so-called gross organic mental defects is to gain as nearly as possible normal contact with normal children. The reverse principle and aim should be the rule in the care of the hereditarily tainted feebleminded child. Here, in fairness both to the child and to society, one should seek for the segregation of the feebleminded, to gain for them a uniform community life.

RESULTS AND FUTURE OPPORTUNITIES IN THE FIELD OF CLINICS, SOCIAL SERVICE, AND PAROLE*

DOUGLAS A. THOM, M.D.

Chief of the Out-patient Department, Boston Psychopathic Hospital

NOTHING that has happened in modern medicine during the past decade has been a greater boon to mankind than the development of an interest in psychiatry, both medical and social, on the part of the community. For the interest and enthusiasm, the toil and endeavor, necessary for the success of such a movement, the names of Richmond, Campbell, Southard, Jarrett, Cannon, and White will be remembered. Public interest in matters pertaining to the mental health of the individual was greatly stimulated by the recent war, so that psychiatry, almost completely ignored for generations even as a medical problem, is now receiving a cordial reception in many fields, such as the schools, the courts, and industry. In the great scheme of preventive medicine, psychiatry has taken its stand well to the fore. In practically every situation, whether it be medical, social, educational, industrial, judicial, or military—in fact, wherever two or more individuals are gathered together—the problem of human adjustment must be considered, and psychiatry in its broadest sense must play its part.

Surprising and regrettable as it may seem, the terms "mental hygiene", "social service", and "psychiatric clinic" are without meaning, not only to most laymen, but to many of the medical profession, who are struggling along blindly, quite ignorant of the facilities at hand. This failure on the part of the public to recognize the fact that the individual must be considered, not only as an isolated being, but also in relation to his environment and the problems that he has to meet in that environment, is perhaps due to the fact that too little stress has been laid upon the importance of presenting

* Read before the Mental Hygiene Division of the National Conference of Social Work, Providence, Rhode Island, June 29, 1922.

the utility and practicability of this broader conception, that we have dealt largely with rather vague generalities, and that no small part of the facilities that the mental hygienist and the propagandist discuss in public exist only on paper.

There is grave danger in that type of propaganda which has a tendency to stimulate the hopes of the public far beyond reasonable expectations. For years past we have been carrying on a most extensive program, providing for custodial care for the insane, the criminal, the pauper, and other unfortunates, preaching a gospel that would give the tax-payer every reason to believe that much could be accomplished in the prevention and cure of mental disease if provisions were adequate. When we are confronted with the facts of the case, however, we find that the discharge rate from our best mental hospitals is only slightly greater than the death rate. We speak all too glibly regarding the preventability and curability of mental disease. Important as it may be to maintain an optimistic and enthusiastic attitude on this subject, it is far more to the point just at this time to face the problem as it really exists and to provide for some practical solution.

The development of out-patient clinics must necessarily be limited by the personnel we are able to obtain, and we are confronted with the fact that neuropsychiatrists, nurses, and social workers exist in numbers that are in no way commensurate with the demands. It therefore behooves us, in drawing up any plans for the future that are to be at all extensive, to consider not only the problem of training personnel, but that of making the most of what we already have.

I know of no way in which the state can do more to care for the mental health of its citizens than by well organized out-patient clinics. Not only do they provide for the treatment of the maximum number of patients at the minimum cost, but they bring the patient into contact with the psychiatrist and his organization during the early and incipient stages of disease. Assistance is made available at a time when treatment is most hopeful, and when the patient is still capable of realizing his own needs. Treatment is given in a manner that makes it acceptable and compatible with the patient's social and economic obligations. It permits him to carry on his work during his rehabilitation and to continue to dwell in

the community, in the environment in which he must manage to live if he is to play a part in the social scheme of things. He learns to carry his burden, not by laying it down and retiring to an artificial environment, but by developing new methods of meeting difficulties, minimizing waste effort, permitting some one else to help in eliminating irritating environmental factors, and thereby overcoming worry and anxiety that are out of all proportion to the situation. Whatever the solution may be, if it is achieved without hospitalization, much has been accomplished for the individual and for the state.

This fact is being appreciated more and more, and the out-patient clinic is becoming a pivot point from which preventive medicine, in so far as it relates to the mental hygiene of the community, is radiated. Ministers, teachers, judges, probation officers, physicians, and lawyers are turning daily to the psychiatrist for advice in regard to the problems of human conduct. But he should not be satisfied with waiting for them to seek him out—he must penetrate and become part of their organizations.

If we consider the out-patient department as the hub of the wheel, the spokes will represent avenues of communication with the general hospitals, the schools, the courts, the various social agencies, industrial concerns, and the state hospitals. To a very large extent, patients pour in from these various organizations and receive their examinations and treatments at the clinic. On the other hand, the out-patient organization should be sufficiently mobile to permit one or more members of its staff to become temporarily part of any health movement that is being carried on, even though it may be quite independent of the organization with which the out-patient department is connected. Nothing except lack of time should hinder the psychiatrist from entering the school, the factory, the store, or the settlement house, and establishing a sub-unit that will greatly facilitate the work, rendering this service in a way that will be acceptable to the organization in question.

At the Out-patient Department of the Boston Psychopathic Hospital, we have one physician attached to the schools, another interested in two different clinics for children of the pre-school age, another in a health movement that is being carried out in East Boston, and two more who act as examiners

of the criminal insane, all these physicians being connected directly with the clinic itself. Such close coöperation between the out-patient clinic and the other organizations that it serves has the advantage of conserving personnel and permitting the various members of the staff to participate in the solution of community problems, giving the physician a broader vision and the community valuable service.

The medium of communication between the hospitals and clinics and those to whom they are endeavoring to render assistance is the social-service department. The out-patient department without a well organized, intelligently equipped, smoothly running machine to aid the psychiatrist in the adjustment of the economic, social, and educational needs of the patient is doomed to failure.

It is my opinion that too much importance has been attached to the necessity of drawing a sharp line of demarcation between the duties of the psychiatrist and those of the social worker. Too much time and attention have been given to debating whether this worker shall be a nurse, a teacher, or a college graduate. I do not mean by this to minimize the importance of selecting personnel for this type of service with the greatest care, for the tasks at hand require a nice judgment with a keen sense of social values and an unbiased mind—one that interprets situations, not from a moral, but from a social point of view. Resourcefulness and diplomacy, an interest in humanity and humanity's problems, and the ability to do teamwork, are all requisite for the success of the social worker. But these characteristics in themselves are not sufficient to assure success in social work, any more than they would assure the success of an individual in the field of medicine or law or in any other profession for which he had not adequate training.

It is easier and perhaps more logical to define the aims and purposes of social work than to make standards for the training that will accomplish the desired ends. There should, however, be an irreducible minimum in the matter of preliminary education and training which would protect not only the client and the public, but social work as a profession. It will be some time before we can hope for a large enough trained personnel—physicians, social workers, and nurses—

to meet the demand, and there is grave danger that in our effort to respond to present-day needs, which have been tremendously aggravated by the World War, individuals who are entirely inadequate will be accepted and recognized by both the medical profession and those interested in social work and will do more to bring discredit upon the profession in one or two years than can be eradicated in a decade.

One cannot read Miss Richmond's last book, *What is Social Case-Work?*, without appreciating the real value of the social worker and the tremendously important part that she plays in the great scheme of preventive medicine. Whether or not we agree with Miss Richmond when she states that "the central aim of social case-work is the maintenance and development of personality", and however intolerable it may seem to the medical profession to relinquish a certain amount of their authority and prestige to this comparatively new profession, the fact remains that, as Plato said, "there are diversities of natures among us which are adapted to different occupations", and, again, "all things are produced more plentifully and easily and of a better quality when one man does one thing which is natural to him".

I do not believe that it is necessary or desirable to define or limit the respective fields of the doctor and the social worker. Just as the treatment of typhoid fever is very largely one of good nursing, so the treatment of most of the problems of maladjustment is dependent on efficient social work.

I am quite in accord with Miss Jessie Taft, who stated at a recent meeting of the National Conference of Social Work,[1] "The psychiatric worker must make a real contribution, must supply the social knowledge and technique the psychiatrist necessarily lacks, and must be capable of extending his usefulness beyond the clinic or hospital by intelligent interpretation of his ideas." If the social worker is to contribute more than good intentions, human interest, neighborly visits, and advice, she cannot depend upon personality alone. It is quite essential that she have a training and an experience that will permit her to take her place with workers in other professions, as her responsibilities are no less important than those of the

[1] See *Qualifications of the Psychiatric Social Worker.* MENTAL HYGIENE, July 1919, Vol. 3, p. 433.

doctor, the lawyer, or the judge. Her technique should be carefully developed along scientific lines, and new methods should be constantly studied with the idea of keeping pace with the other professions. Research should go hand in hand with routine. There is great danger of becoming too self-satisfied with the accomplishments already attained and of forgetting for the moment that the development of social technique is still very much in the making. Every department of social work should turn out at least one piece of research every year.

The psychiatric personnel in this country, as in every other, is, as we have said, quite inadequate to meet the demand. There is, therefore, a grave necessity for conserving the time of the psychiatrist in so far as possible, and there is no doubt but that the well-trained psychiatric social worker can assume more responsibility than we have heretofore permitted ourselves to believe.

Since the tendency is to broaden the scope of the social worker's functions and to increase her responsibilities, it will become more and more necessary for her to have not only a thorough knowledge of the community and all its resources, together with its dangers and pitfalls, but also an insight into the mental make-up of the patient as well as his social environment in order that she may evaluate properly all the factors involved.

If out-patient clinics and the parole system are to have the opportunity of demonstrating their practical value, the community must be educated to understand that there are certain responsibilities which it must assume. We are prone to shift burdens and discomforts to the other fellow's shoulders, and it is with great reluctance that we undergo any social inconvenience for the sake of our neighbor. We forget for the moment that our own escape from social catastrophies has been rather a matter of luck than of judgment or foresight. A little more consideration of our own good fortune would render us more tolerant of our neighbor's misfortunes—would perhaps make it easier for Mr. Jones to keep his defective boy at home instead of putting him into an institution, or for Mrs. Smith to treat more sympathetically the social indiscretions of her sixteen-year-old daughter; and it

may be that the old lady across the way could spend her last days at home instead of at the poor farm or the state hospital if just a little more patience and compassion could be stimulated in the younger members of the household.

We are all trying to get an environment free from responsibility, a frictionless sort of existence, forgetting that there are certain inconveniences, irritations, and social burdens which it is our duty, as citizens in a community, to assume and which we have no right to shirk. To make the community feel and assume its responsibilities toward those who are less fortunate is one of the great opportunities of the clinics and the social worker.

I know of no better example of what I mean by community responsibility than that which is exemplified at the little village of Gheel in Belgium. Many of you, I am sure, are familiar with this colony. Since the end of the sixth century it has been a refuge for the mentally disturbed. First those who lived nearby came to the tomb of the Virgin simply to pray. Later, pilgrimages were made from distant parts in search of a cure. The pilgrims procured board and room in the homes near the church, and from then on until the colony was reorganized by the Belgian state in 1852, much unorganized, though sympathetic work was done by those whose social heritage gave them more than ordinary insight in caring for the mentally diseased. In 1852, the colony was taken over by the state and has since achieved a world-wide reputation. After thirteen centuries of contact with the mentally diseased, the family care of the sick has become a habit almost necessary for the life of the population of this little village. But not all who wish may care for the sick. Before being accepted, the applicants must prove that they are of good character and that they possess certain surroundings of comfort. The choice of a family is the most important and delicate question to be met. An attempt is made to retain for the patient his natural habits of life. An artisan is placed in a family pursuing the same line of work as his own; patients who come from cities are placed in the families of citizens living in the center of the town, and peasants are lodged with farmers.

During the German invasion of France, the villagers of

Gheel opened their doors to refugees from one of the hospitals for mental disease on the border. I was told by Dr. Sano, Director of the Gheel Colony, that he never witnessed a more pathetic scene than the departure of these refugees from their Belgian hosts in the spring of 1919. These villagers are as much interested in their patients as they could possibly be in a member of their own family. I have visited their homes personally and have seen demonstrated there the true spirit of community responsibility.

It is too much, of course, to ask or to expect a duplication of the Gheel system, but it is not too much to demand more community coöperation than we are getting at present.

There are many ways in which the problems presented to an out-patient clinic might be divided, but for purposes of convenience and brevity, I will use a very simple clinical grouping—that is, into the psychotic, the incipient psychotic, and the psychoneurotic. Of the psychotic group, naturally a large proportion are referred directly to a state hospital. Many of these frankly psychotic cases, however, present no particular asocial traits and can be cared for quite satisfactorily in the community if adequate supervision can be provided. Not only can many of these cases be given the proper care in their homes, but they can be made economically independent, or at least partially so. I would call your attention to a recent article by Dr. George K. Butterfield,[1] of the Danvers State Hospital, which indicates that 40 per cent of the cases that were discharged against advice or that escaped got along quite successfully from an economic and social point of view after leaving the hospital, while 76 per cent of the cases that went out on advice succeeded. *I believe that with adequate social-service supervision* and with a well organized boarding-out system, there would be for many years to come *no necessity* for the present tremendous outlay on new construction in state hospitals in such states as New York and Massachusetts, and that if a small portion of the money saved could be used for research, something at least would have been accomplished in the way of eliminating the vast army of mental wrecks. I can only mention in passing the desirability

[1] *What Happened to Discharged Patients. American Journal of Psychiatry*, October 1921, Vol. 1, pp. 177-82.

of having all patients who go out from psychopathic hospitals and state hospitals discharged through the out-patient departments, and the value of a well organized follow-up service which would permit us to see these patients as frequently as necessary for the purpose of preventing a recurrence of the mental breakdown that brought them to the institution. These cases are so numerous and so familiar to you all that I will not cite examples. Yet perhaps it is because of their very numbers and of the fact they are of such a common, garden variety that they are either neglected or ignored.

The second group, the so-called incipient psychoses, are perhaps of more practical interest, inasmuch as with them we can hope to do something in the way of genuine preventive medicine. It is our aim in dealing with these cases to forestall a mental breakdown by the application of the principles of mental hygiene. The following case is a good example of this group:

A young girl, nineteen years of age, was brought to the clinic by her father, who stated that for the past three or four months she had been telling most unusual and fantastic tales to the girls at the normal school that she was attending. She made it generally understood at the school that her mother had left her husband, had remarried, and was living in France. She showed her companions letters supposed to have been written to her by her mother. She discussed, rather intelligently, the economic, social, and educational conditions in France, and told of her plans to go there after finishing her course. Later on, she came to school and told of the death of her father, which created a great deal of sympathy among her friends, and immediately contributions were taken up to send flowers. It happened that this story became more generally known than the others she had told, and some one who knew the facts of her case communicated with the teacher. It was at this time that her fabrications for some months past were revealed, and she was advised by one of her instructors to come to the hospital.

She was a girl of more than average intelligence, had succeeded well in her studies, but had fallen down entirely in making friends and in getting enjoyment out of the more ordinary things in life. She was inclined to view life rather

seriously and had made but one confidante, a woman who had been her teacher when she was in the sixth grade. She had no intimate companions, and she felt that she had never been understood. She stated: "Mother half understands me, father not at all." Recently her school work had deteriorated in spite of the fact that she was staying up until four o'clock in the morning to get her lessons. A discussion of the situation with the father made it quite obvious that he had no understanding whatsoever of the girl's condition. He said: "Instead of bringing her here, I ought to put her up against the wall and smash her face." He felt that the fabrications were purely voluntary on her part, and that she was ashamed of the rest of the family. The mother seemed to be a rather sensible, hard-working woman, who, like the other members of the family, was very subservient to the father. She was making a great effort to shoulder the responsibilities of the household, not only caring for the house and for the three children's physical needs, but always having in mind that it was her duty to keep them happy and contented. She expected little and got less from her husband. From her story and the interviews with the father, there was no doubt that he was the dominant member of the family. Everything revolved around him, and he was most exacting in his demands for obedience. When he entered the house, the mental atmosphere changed immediately—everything must quiet down, meals must be served exactly on time, children must be put to bed at the proper moment, conversation must cease or be initiated by him. The wife stated: "He is a hard worker and a good provider, but the job of police inspector is extremely trying and nerve-racking." It was quite obvious that much of the irritability developed during his work was expended in the household.

It seemed quite apparent, from the analysis of this case, that the romancing and fabricating—for which, by the way, there were certain definite amnesic periods—represented an effort on the part of the patient to emancipate herself from the tyrannical autocracy of her father. The only road to happiness seemed to necessitate a withdrawal from reality and a refusal to meet the problems of everyday life as they were presented. It necessitated further the building up of a

little dream world of her own in which many of her desires, hopes, and ambitions could be realized. After going over the situation carefully with the mother and the father, it seemed advisable to change the patient's environment, temporarily at least. Fortunately a position was secured for her in a home as governess for two children, under very favorable conditions. At the same time opportunities of adjusting her life in a way more compatible with her personality were offered. Improvement was immediate and marked.

Such problems are being presented daily, and the solution of them is largely dependent upon efficient social service, the type of social service that can bring to the task an understanding of the mental make-up of the patient as well as the social technique required to handle an antagonistic, dominant individual like this girl's father, on the one hand, and the refined family in which the girl was placed on the other.

The psychoneurotic group makes up a very large per cent of all cases that receive treatment in the out-patient clinics, and it is with this group that we can best hope to be of real service. It is, perhaps, of interest to note that of all the patients seen at the out-patient clinic carried on by the United States Veterans' Bureau in Boston, less than 5 per cent are sent to hospitals for treatment, while in a Middle-Western city handling presumably the same group of cases, they find it necessary to hospitalize over 70 per cent of the cases. The reason for this wide discrepancy lies in the fact that in the one city there is a well organized out-patient clinic and an efficient social service, while in the other these facilities are not available. This is a good example of the value of clinics and social workers. Permit me, however, to present one individual case, with its ramifications, to illustrate how intricate and involved an apparently simple situation may become if intensively studied:

C. D., a woman fifty-six years of age, entered the Out-patient Clinic of the Boston Psychopathic Hospital complaining of weakness on the left side of the body, confined very closely to an extensive area that had been burned seven years ago, involving the left arm, breast, abdomen, and leg. There were also rather vague subjective sensations which were not

constant or characteristic of any nerve lesion. Careful physical and neurological examination revealed no organic cause for her complaints. In taking the history of the case, it was observed that the patient was depressed, extremely sensitive, and reluctant about going into the details of her early life. It was finally ascertained, however, that thirty-one years before she had had an illegitimate daughter by the man whose name she bore. Notwithstanding the fact that this man was a moral degenerate, socially her inferior, and abusive, she was extremely fond of him, and while not living with him, was at his command at all times over a period of twenty years. When their illegitimate daughter was seventeen years of age, her father had immoral relations with her which the mother knew nothing about until some years later. At the time of her coming to the clinic, the patient was living with this daughter—in fact, she thought that she was entirely dependent upon her daughter and her son-in-law—and it was made quite plain to her that she was not wanted.

This woman had converted many of her mental conflicts into physical symptoms. After going over the situation with her, a plan of life was outlined, and one of its most important features was that she have a home of her own. The patient then requested that she be allowed to bring her daughter to the clinic, and this she did.

The daughter was a well-developed and well-nourished young woman, thirty-two years of age, who was extremely depressed at the time of the examination. She gave a history of spells of excitement, when her thoughts seemed accelerated and prevented her from sleeping. Her married life had been extremely disappointing, as there was no real affection between her and her husband. She found life a very solitary affair, and could not meet people, as she was unable to appreciate any interest outside of herself. She was constantly seeking sympathy, attention, and romance. She had been extremely disappointed in not having any children and had made no effort to fill in the vacuum by outside interests. The husband of this woman was a hard-working man who had but little understanding of his wife's condition. He was, however, extremely coöperative and wanted to do everything that he

could to help out. He resented somewhat the presence of the mother-in-law and felt that much of their trouble was due to her interference.

The case was referred to the social-service department, it was arranged for the mother-in-law to establish an apartment of her own, and an effort was made to develop the daughter's interest in some of the social activities of the community. She took up gymnasium work and developed an interest in birds and flowers, and through constant attention and effort on the part of the social service, much improvement was made in the situation, to the satisfaction of all concerned. After a few months, however, the patient again became depressed and at the present time is just getting established again. The whole setting is quite obviously one for very intensive social work. The skill and ingenuity of any worker will be taxed to the limit to develop plans to solve this problem, and it is too much to hope that success will be achieved without one or more failures.

One of the chief rôles that the psychiatrist is called upon to play is that of arbiter. Some one has wisely said that "neuroses, like charity, begin at home", and this is well borne out by one's experience in out-patient work. The cases in which the solution of the problem depends in a large measure upon the proper adjustment of family situations outnumber any other group, and this is not surprising when one considers the intimacy necessitated by close personal contacts and the innumerable sources of irritation that are ever present. Many of the problems that are presented for solution are complicated and involved, but in general it is not so much the problem as the method by which it is handled that produces at first an unhappy mental atmosphere, later disputes and quarreling, and finally a situation in which more abnormal methods are utilized in an effort to bridge over the difficulty. These abnormal methods may be drugs, alcohol, convulsions, fainting spells, and not infrequently homicides and suicides.

I can only mention briefly a new phase of work started in connection with the Baby Hygiene Association which the psychiatrist and the social worker will coöperate in carrying out.

This is the establishment of habit clinics for children of the pre-school age. The study of children and of the influences that modify habits is what might be called a pure culture of mental hygiene. The heredity, personality, and environment of these immature children all need careful investigation. Instincts and emotions are studied in relation to the various personality defects or undesirable habits that usually make up the presenting symptoms. The opportunity for the application of high-grade social technique in this group of cases is unlimited, and the time is not far distant when this field will be receiving the attention it so richly deserves. The following are only a few of the typical problems presented at the habit clinics for solution:

P. F. Age two years, nine months. Beats, kicks, slaps, and bites other children. Has violent tempers and night terrors. Wets the bed every night; also wets clothing during the day.

J. Y. Age five and a half. Refuses food. Has fainting spells when threatened with punishment. Sucks his thumb.

F. D. Age three and a half. Intense fear of dogs. Very shy. Terrifying dreams.

I. S. Age five and a half. Refuses food unless fed by mother. When left alone with her food, hides it, and then tells fanciful tales of what has happened to it.

F. J. Age two years. Intensely jealous of little sister aged four. Resentful and sullen. Makes vicious attacks upon sister, usually biting and scratching.

H. H. and G. H. Ages five and six and a half respectively, sisters. H. H. for past three weeks has had persistent vomiting one or more times daily. Has always been a bed wetter. G. H. walks in her sleep and is also a bed wetter.

X. Age three. Very shy; always sits back and watches the other children at play, taking no active part.

X. Y. Boy sent in for cruelty. Tied cat and killed it, hitting it over the head, and so forth.

C. F. Age six. For the past two years has presented very marked sex interest. Takes her little sister to the park some miles away and leaves her. Goes out in the morning for school and does not return until late at night. Frequently picked up by the policemen. Hangs around the moving-picture shows, lies and steals.

D. H. Within the last six weeks since he has been on a farm, has developed unusually cruel tendencies. Was found on one occasion beating a newborn calf with a belt and buckle. On another occasion had gathered together with considerable time and effort a large pile of stones in such a strategic position that he could corner the cows and pelt them. Very ingeniously made a bow and arrow which he utilized to kill chickens, and never passed a cat or a rabbit without throwing stones. Investigation showed that these traits had been passed down through three generations.

My effort has been directed toward emphasizing what appear to me to be fundamental points in the organization of efficient out-patient clinics and the rôle that social work should play in the development of these clinics. To many of my readers I am sure it has been simply an elaboration of the obvious. Yet the profession of social work is young and in many fields not too well established, but little appreciated, and frequently only tolerated as a necessary evil. The idea is still prevalent that the highest aims and purposes of social work are to dispense advice to the patient and to make recommendations to the social agency interested in him. These ends are important and should not be minimized, but the really vital thing is the constructive work that can be done for the patient in helping him to meet the demands of the immediate situation, and this work requires personality, judgment, training, and experience. The recognized future development of social work, and the fact that its achievements must ever be closely interwoven with those of the other professions and of industry, demand ideals and standards that will not only insure its success, but will permit medicine, law, education, and industry to profit by its endeavors.

A STUDY IN CONSTITUTIONAL PSYCHOPATHIC INFERIORITY*

JOHN W. VISHER, M.D.

Twin Falls Clinic, Twin Falls, Idaho; formerly Assistant Surgeon (E), United States Veterans Hospital 57, Waukesha, Wisconsin

THE solution of the numerous psychiatric problems of the late war greatly advanced our knowledge of the broader aspects of psychiatry. The study of mental mechanisms and their effect on personality was especially fruitful. The fundamental lesson learned was that the psychogenic factor was of prime importance in the war neuroses. The recognition of this fact added impetus to the study of personality, for it was recognized that permanent relief of the war neuroses could be obtained only through such a study of individual cases. Thorough work disclosed many deviations occurring in all the attributes of the personality. A natural result was renewed interest in that small, but important group of inadequate personalities to which the name constitutional psychopathic inferiority is now frequently applied.

No other psychiatric disease group is the subject of so much discussion and difference of opinion. Many textbooks on psychiatry do not mention it, while others discuss it under various names. In 1835, Pritchard, a French alienist, applied the term "moral insanity" to "those diseases in which there exists a perverse state of feelings, temperaments, dispositions, habits, and actions, while the intellectual functions present no apparent abnormalities". Later, Lombroso attempted to define the born criminal and to identify him by physical stigmata. Diefendorf,[1] in his adaptation of Kraepelin's *Lehrbuch der Psychiatrie,* discussed the subject well from a descriptive standpoint under the term "psychopathic personalities". Tredgold[2] discusses this group under the head-

* Authorized for publication by the Surgeon General, United States Public Health Service. Read before the Section on Nervous and Mental Diseases at the Seventy-third Annual Session of the American Medical Association, St. Louis, Missouri, May, 1922.

1 Diefendorf, A. R.; *Clinical Psychiatry,* Edition 2. New York: The Macmillan Company, 1921. P. 516.

2 Tredgold, A. F.; *Mental Deficiency,* Edition 3. New York: William Wood and Company, 1920. P. 348.

ing "moral imbecility" and takes his definition from the British Mental Deficiency Act of 1913 which describes moral imbeciles as "persons who from an early age display some permanent mental defect, coupled with strong, vicious, or criminal propensities, on which punishment has had little or no deterrent effect". Rogues de Fursac and Rosanoff[1] describe the group under the heading "constitutional psychopaths", but include what are generally considered anxiety neuroses, psychasthenia, and moral insanity in their discussion. Salmon[2] says of psychopaths that "they have a tendency to react toward difficult situations in a neurotic or psychotic way, or have defects in volition or emotional control which make adaptations that are very simple for others very difficult for them".

Extensive experience with and intensive study of fifty typical psychopaths in United States Public Health Service Hospital No. 37, Waukesha, Wisconsin, has demonstrated the need for a more satisfactory definition. The following is offered as a working hypothesis and should be considered as purely tentative.

From the psychological standpoint, the constitutional psychopathic inferior presents marked inherent defects in volition and inhibition, together with a lowered threshold for and a disproportionate response to implicit and explicit stimuli. There is also a lack of balance in the various hereditary and acquired reaction patterns and habit systems. The individual is unable to adjust to his inadequacies, either by means of experience or by the formation of compensatory modes of reaction. From the behavioristic standpoint, the condition is characterized by marked egotism, impulsiveness, poor judgment, nonconformity to ethical and social standards, and inability to adjust to or to profit by discipline.

The defect in volition of the constitutional psychopathic inferior not only makes it difficult for him to concentrate or to apply himself, but also makes it almost impossible for him to hold to one course or action long enough to succeed. Hence,

1 De Fursac, J. R. and A. J. Rosanoff; *Manual of Psychiatry*, Edition 4. New York: John Wiley and Sons, 1916. P. 339.

2 Salmon, T. W.; *Some New Problems for Psychiatric Research in Delinquency.* MENTAL HYGIENE, January, 1920, Vol. 4, p. 37.

many become industrial misfits, loafers, beggars, and paupers. The combination of this quality with an unusually strong desire to travel produces the hobo and the vagabond.

His poor inhibition makes him particularly prone to the commission of crimes of passion and the perpetration of sensual excesses of all kinds. It is because of this inadequacy that a large proportion of alcoholics, drug addicts, prostitutes, and sexual perverts fall into this group.

His egotism, boldness, and vanity, as well as his tendency to become a leader of gangs, a fanatic reformer, an assassin, or an anarchist, are explainable by the mechanism of overcompensation. His irritability and his tendency to blame his family, his associates, his employers, the injustice of the law or of those in authority for his failure can be explained by the mechanism of projection. His inadequacies are subconsciously dominant, but he cannot consciously admit that they are the cause of his failure and therefore projects them upon his environment.

His emotional instability and impulsiveness bring him into continual conflicts with his family, his employers, and his associates. This maladjustment engenders innumerable internal conflicts and painful repressions. Bitterness, cynicism, and neurotic, psychoneurotic, and psychotic manifestations frequently result.

His lack of judgment distorts his point of view. It has been often truly said that the psychopath does not see things as they are. This makes him peculiarly liable to the development of numerous eccentricities and the adoption of unsound beliefs. Where there is also a lack of ethical sense, he too often becomes a crook, a charlatan, or a quack.

His nonconformity to social and ethical standards is due partly to his defective inhibition, partly to his emotional instability, but chiefly to his tendency to follow the course of least resistance. He does not profit by experience and teaching, and so follows his own inclination without proper thought of the consequences. The opinion of society has little deterrent effect. Hence, the psychopath commits numerous antisocial acts and feels no remorse. He lies, swindles, steals, and even kills to gain his selfish ends, without due consideration of possible retribution.

The cause of his inability to profit by discipline is evident from the foregoing description. It is especially important, however, for it explains the failure of our penal institutions in dealing with this class. In fact, Glueck[1] has shown that not only does the psychopathic group furnish a large number of the first admissions to penitentiaries, but it also includes an even larger proportion of the recidivists.

Statistical Study of Fifty Psychopaths

A very careful review of the hospital records of fifty psychopaths discharged from this hospital between March 30, 1920, and September 13, 1921, was made and certain statistical facts were gleaned that may be of interest. Although many of the statements of the patients were checked by information obtained elsewhere, it must be admitted that the data concerning industrial failures, arrests, and delinquencies are not in all cases entirely reliable. Since the patient was always given the benefit of the doubt, what errors exist are on the side of leniency.

A history of a neurotic family was obtained in twenty of the fifty cases. This means that one or more members of the patient's ancestors or their siblings showed evidence of a definite neurosis or psychosis or of aberrant conduct pointing toward the psychopathic.

The educational status of the fifty men is interesting in that over half attained the eighth grade or higher. The following table gives this information in detail:

Table 1—Educational Status

Left school in first to fourth grade	7
Left school in fifth grade	5
Left school in sixth grade	3
Left school in seventh grade	5
Left school in eighth grade	12
Left high school during course	10
High-school graduates	4
College graduates	1
Military college	1
Unascertained	2
Total	50

[1] Glueck, B.; *Recent Progress in Determining the Nature of Crime and the Character of Criminals.* Reprint No. 116 of *Addresses of the National Conference of Social Work*, 1917. P. 10.

A study of the economic efficiency of the fifty before their entry into military service shows that eight had a good industrial record, eleven had a fair record, and twenty-five had a poor record. Of the remaining six, five had spent most of their life in the army since leaving school, and the record of one is unknown.

Twenty-six admitted having been arrested; nine had been confined to jail for longer or shorter periods; and two had served terms in penitentiaries. By accident it was learned that two others had been sent to reform schools. It is obvious that the above represents only a small proportion of the conflicts with the law that these men have had. The surprising thing is not that there are so few with a court record, but rather that any should have admitted that they had been arrested.

Their marital histories also show numerous evidences of maladjustment. Of the seventeen who have been married, three are separated, four are divorced, two have divorces pending, two are bigamists, and one has been married three times and divorced twice.

Adjustment was attempted by six by means of morphine addiction, and five others were addicted to the abuse of other drugs. Of the latter, acetanilide, "bromo-seltzer", veronal, sulfonal, and cocaine were the most important. Only two were definitely classed as alcoholic, though several others had drunk to excess at some time in their lives.

Military life appeals to the psychopath in many ways. It offers excitement, idleness, and male companionship. It is especially attractive as a socially tolerated outlet for the *wanderlust,* which is present in most psychopaths and was marked in thirty-four of our cases. Lack of adjustment to military discipline with resulting court-martials are not infrequent, though only two such trials were admitted by our cases. Deserters are common among psychopathic soldiers, but as they are not entitled to hospitalization, none of our series admitted such conduct. The more favorable side of the problem is illustrated by the following facts: Of the fifty psychopaths in this series, fourteen had entered military service from two to four times, while six were in the regular army and eight in the National Guard when the United States

entered the war. Only fifteen were drafted, while the remaining thirty-five enlisted. Ten were promoted—five to sergeant, two to corporal, and three to corresponding ranks in the navy.

The industrial record of our patients since discharge from the service demonstrates how completely military life unfits the psychopath for real work. Thirty-two of the fifty worked less than 10 per cent of the time from the date of their discharge from the service to the date of their discharge from this hospital. Table 2 gives detailed data concerning the percentages of time at work and time idle for the entire series:

Table 2—Industrial History since Discharge from Military Service

Per cent of time	Number at work	Number idle
10 per cent or less	32	3
11–20 per cent	4	3
21–30 per cent	5	5
31–40 per cent	3	5
41–50 per cent	1	5
51–75 per cent	2	16
76–100 per cent	0	10
Unascertained	3	3
Total	50	50

All of the nine men who were granted vocational training failed to complete their courses or to be even partially rehabilitated. Several tried more than once, and one tried three different courses, failing in all.

Failure in work and failure in vocational training, and the general restlessness and unhappiness resulting from poor adjustment, convinced the psychopath that his health had been ruined by his military duties. His friends and relatives too often agreed with him and confirmed him in his invalidism. Then, when a benevolent government offered him hospitalization and the hope of compensation, the final step in his downfall was assured, and he came to the hospital with his morale at zero, and his egotism, self-pity, and idea of his own importance at their highest.

A study of the series for organic factors shows that only three of the fifty men had somatic conditions of sufficient importance in themselves to warrant hospitalization. Four others had active venereal disease requiring treatment that

could have been administered in an out-patient clinic. Several others had minor organic conditions of which they were making capital, but which were either not disabling or were stationary in character, and obviously not in need of hospital treatment. So that in forty-seven of the fifty cases, hospitalization was chiefly for symptoms referable to constitutional psychopathic inferiority.

Hospital treatment of the psychopath is of little or no benefit to him and may be positively harmful, as it prolongs his invalidism. His influence upon the other patients is even more pernicious, as he is usually a fault finder and an instigator of trouble. Under these circumstances, the record of hospitalization of these patients in the military service and since discharge is of special importance. Table 3 gives the proportion of time spent in hospitals during service and after discharge from the service:

Table 3—Hospitalization

Per cent of time	Number hospitalized during service	Number hospitalized since discharge
10 per cent or less	16	10
11–20 per cent	5	11
21–30 per cent	7	7
31–40 per cent	9	6
41–50 per cent	6	4
51–75 per cent	4	5
76–100 per cent	1	5
Unascertained	2	2
Total	50	50

It will be noted that in each period twenty men spent 30 per cent or more of their time in hospitals. The average length of time spent in a hospital by each patient during and subsequent to service is 10.6 months, an astounding figure. Additional evidence of the magnitude of the problem is gained by a study of the number of hospitals in which each has been treated since discharge. Five had been patients in two hospitals; seventeen had been in three; and eleven had been in four or more hospitals. In addition, several had been admitted more than once to the same hospital. Probably many have been admitted to other hospitals since leaving this one, and doubtless the beginning has just been made in the institutional care of this group of social misfits.

Classification of Types

Careful study of these patients has made their classification into certain types seem useful. There are, however, no hard-and-fast lines separating these types, and reclassification may be necessary in the future. Each of the five following cases was chosen to illustrate a certain type. Additional types not illustrated are the chronic alcoholic, recently well described by Janet,[1] and the various types characterized by pathological sexuality, so thoroughly discussed by Krafft-Ebing.[2]

Inadequate-personality Type

N. F. S. was born in 1887, of Bohemian parents, in a small Wisconsin town. His maternal grandfather died at seventy in an old soldiers' home, while his father, who is sixty-three, has been in a charitable home for twelve years, apparently paralyzed. At the age of thirteen, when in the fifth grade, the patient was committed to the state reform school on the charge of incorrigibility and truancy. He remained there until seventeen, having finished the eighth grade. After release, he worked at many different jobs with only fair efficiency. He became a cornet player and played in several bands, and toured the country for several seasons with circuses and shows.

His habits, sexual and otherwise, were not unusual. He was compelled to marry at twenty-seven to legitimize a child, but separated from his wife a month later. He enlisted in the army June 21, 1916, and served on the Mexican border. He went overseas in February, 1918, but soon thereafter was hospitalized and remained in hospitals for eleven and a half months. The adjutant general reports that he was diagnosed "psychosis, hysterical and hemiplegia". While en route to Camp Grant for discharge, he went A. W. O. L. for eleven days. He was discharged March 9, 1919, without disability. Since discharge he has done no productive work. He started vocational training in tree surgery, but discontinued it after a month because he did not like it.

1 Janet, J. M. F.; *Alcoholism in Relation to Mental Depression*. *Journal of American Medical Association*, November 5, 1921, Vol. 77, pp. 1462–67.

2 Krafft-Ebing, R. von; *Psychopathia Sexualis*. St. Louis: C. V. Mosby Company.

He was admitted to this hospital April 14, 1920, and remained until July 2, 1920. He suffered with minor physical conditions which were in no sense disabling. The history given by him on admission differs markedly from the foregoing, and is full of proved falsehoods. It is of interest that he has "lost" his discharge certificate, probably intentionally. It was definitely proved that many of his alleged disabilities were simulated. For example, he claimed to have a paresis of the right side of the face and lips which prevented him from playing the cornet. This was shown to be spurious.

His conduct in the hospital left much to be desired. He was uncoöperative, unruly, uncivil, and often insolent. He was an instigator, continually stirring up discord. He paid no attention to the rules of the hospital. His delinquencies were numerous, but minor, as he apparently never committed any crimes. He did not like work and tried in every way to escape it. He has achieved his purpose, for, after leaving this hospital, he was given vocational training in chiropractic.

Hobo Type

W. G. R. was born in Chicago in 1892, of American ancestry and of good family. His early life was not unusual, and he finished grammar school at fourteen. He ran away from home at this time and has been leading the life of a hobo ever since. He bragged that he had been in every state in the Union as well as in Alaska, Canada, Mexico, and Panama, and that for two years he stayed less than ten days in a town. He traveled from place to place on freights or on the "blind baggage". He has worked as painter, structural steel worker, bricklayer, and carpenter. He has been arrested and jailed on several occasions for riding freights and for vagabondage. He has lived with several different women, but has never been married. He enlisted in the Engineering Corps of the army in March, 1918, and was sent overseas. He claimed to have overexerted himself rolling logs, and was treated in several hospitals for "nervous" symptoms. After discharge from the army, July 8, 1919, he recommenced his vagabondage, riding box cars from place to place and begging. For the eight months prior to his admission here, he had been treated in several Public Health Service hospitals. After he had

been here two months, the *wanderlust* again asserted itself, and he demanded his discharge from the hospital. He was very egotistic, self-confident, uncoöperative, fault-finding, and unruly. He had a marked, unwarranted hatred for his family. His inadequacies of personality, lack of ethical standards, strong sexual passions, and roving disposition had made a vagabond of him.

Pathological-liar-and-swindler Type

W. G. R. was born in Boston, Massachusetts, April 25, 1897, of English parentage. His father writes in the following manner concerning himself: "I was one of those hare-brained, foolish young fellows who did not care if I was in China or the United States of America. I loved to travel and never gave to-morrow a thought. I did not drink to excess. I was brought up well and in good surroundings, but was wild, full of nervous energy, and very sensitive; quick-tempered, fly up at almost anything, in fact out of all reason. My father was the same. This changed ten years ago. I have great self-control now." His father writes that he is a "government investigator" and has a large family. The patient's mother is living and is apparently quite normal, and his brothers and sisters show no marked neurotic taint. He was sent to school in England, but left at fourteen in the seventh grade of his own accord. At about this time he ran away from home without reason, but returned after ten days of his own accord. Later, exact date unknown, he ran away to enlist in the Canadian army. He became a sergeant in the Canadian Highlanders, but was not sent overseas and was discharged because of "physical unfitness". He joined the American navy May 3, 1920, and was discharged on medical survey September 14, 1920. He was at once admitted to the Marine Hospital in Chicago and remained there until October 29, 1920, when he was admitted here. He absconded from this hospital November 28, 1920, and returned to his father's home in Atlantic City, New Jersey.

Upon admission to this hospital, he gave a long, detailed account of his past life, telling of being a captain in the Royal Flying Corps, serving on the French, Italian, and Asia Minor fronts. He told of four "crashes" he was in and of long

periods of hospitalization for "shell shock". He claimed to have been in the air 2,250 hours. He said that his mother's hair turned gray overnight because of worry when he was flying, and that she died a week later of a "broken heart". He said that his father was a wealthy paper manufacturer and that he expected his father to furnish him with capital to start a shop in Chicago for the designing of women's gowns. While in the navy in the hospital, he told even more fantastic tales. He pretended to have a relapse of his "shell shock", collapsing when a truck back-fired near him. He did not walk for some weeks and demanded and received very special privileges. Upon leaving this hospital, he borrowed $15 from one patient, a suit of clothes from another, and a suit case from another, telling them that he was going on a pass. He left at least one hotel in Chicago without paying his bill. His father wrote of his son that "he would tell lies without any reason on earth for doing so". The patient appeared to be very refined, well-informed, and well-behaved. There was a certain personal magnetism about him that inspired confidence. He talked glibly and told his most fantastic yarns in so plausible a manner that he deceived every one for a time.

This case is remarkable in that it is almost a pure case of *pseudologia fantastica*. There were, to be sure, some unpaid debts and unreturned property, but the responsibilities of life rested lightly on his shoulders and he probably had no real conception of the gravity of his offenses.

Drug-addict Type

B. W. A. was born in Kansas City, Missouri, in 1896, of American parents, who were separated soon after his birth; he was adopted by foster parents at the age of three. His early life was apparently not unusual, except that he left home at sixteen and became a messenger boy. While engaged in this work, when seventeen years old, he acquired the heroin habit from the addicts to whom he carried the drug. He later worked irregularly as a chauffeur and as a dyer and cleaner, but admitted that he used to "hobo" three or four months of each year. The remainder of the time he would impose for the most part on the generosity of his foster parents, and, as he expressed it, "bum around town". At

about twenty he changed from "sniffing" heroin to using morphine hypodermically. He admits having been arrested many times, usually for morphinism, and serving several sixty-day sentences in jail. He stated that he had taken the "cure" at least eight times, though it is questionable whether he was ever off the drug entirely.

He was drafted September 3, 1918, but was discharged on Surgeon's Certificate of Disability for morphinism on March 10, 1919. He fraudulently reënlisted May 26 and was again discharged for the same reason September 8, 1919. During his second term of service, he acquired syphilis and gonorrhea. On November 11, 1919, he was admitted to a United States Public Health Service hospital and was treated for his morphinism on an open ward. While there he obtained all the drug he desired from outside sources, so did not benefit by his treatment. He was transferred from that hospital to this one, to which he was admitted February 24, 1920. Upon admission he said: "Unless you can give me some drug that will make me feel better than morphine, I would rather keep on taking it." He held to this attitude throughout his three and a half months' treatment here, which was directed chiefly against his syphilis and gonorrhea. For his drug habit he refused to accept treatment in isolation. He was surly, irritable, untruthful, and uncoöperative. He had numerous inadequacies of personality and used his morphine addiction as a means of sublimation. He knew from experience that without morphine life was to him a hollow mockery, and so clung to it as the only method he possessed of making life bearable.

Criminal Type

P. A. R. was born in a small town in Missouri of parents of Irish descent. His mother is markedly hysterical. He claimed to be unable to remember anything about his childhood, his schooling, or his occupation before entering the military service. He failed to recall even the town in which he lived before entering the service.

He enlisted in the army July 22, 1916, and arrived in France October, 1917. He served on several fronts, and his discharge certificate states that he was "wounded, gassed, and

shell-shocked". He insisted that he remembered nothing about these experiences and repeatedly stated that he did not think he had been overseas. After returning from France, he was treated in several hospitals, but his memory of this period also was very hazy. He was discharged without disability. Since his discharge, he has done only a few weeks' productive work and has been living on his compensation. He was given placement training for a month, but failed to make good. He was treated in several other Public Health Service hospitals before being admitted here January 30, 1921. He complained of almost complete loss of memory for the entire period of his life except the last few weeks.

Extensive correspondence with American Red Cross chapters, Public Health Service psychiatrists, and police departments of cities all over the United States brought to light ample reason for this patient's apparent amnesia. He was released from the Indiana State Penitentiary to be allowed to enlist in the army. While in Paris, he was under indictment for stealing government automobiles. He pretended that he was the son of two different wealthy families by the name of R——, whose sons were unaccounted for, in an attempt to secure money from them. He was met by the father of one and the mother of the other upon landing in New York City. He eloped with a wealthy divorceé in her father's car. He tells several different stories as to the place and date of his marriage to this woman. At least once he impersonated an army officer, wearing a lieutenant's uniform. On one occasion, he traded off his employer's Ford as part payment on a larger car, and sold the latter, keeping the proceeds and telling his employer his car had been stolen. He stole another car in Detroit, sold it, and was brought back from California to answer to the charge. He has obtained money often from the American Red Cross on false pretenses. Special examination of eyes and ears demonstrated definite malingering. He made application for additional compensation, claiming two dependent children, and later admitted that he had no children. As a rule he was polite and agreeable, a very smooth and convincing talker, which doubtless explains how he has been able to escape imprisonment so

long. When questioned about certain of his past experiences, he would state that he remembered nothing about that period of his life; but when he learned that his questioner knew something about these episodes, his "memory" would return and he would explain away the difficulty very glibly, usually by means of more fabrications.

This case is typical of the more intelligent criminal who cleverly eludes detection and conviction. It is unusual, however, in the matter of the capitalization of an alleged amnesia. The pretended amnesia was truly spurious and could be quite completely dissipated by careful analytic psychiatric examination, but, as it had become a great asset to him, he could not be induced to relinquish it.

Diagnosis

The diagnosis of constitutional psychopathic inferiority can usually be made after prolonged observation and thorough study of the past history of the patient. It is essential to obtain information from outside sources. In this hospital, special stress is laid on the degree of industrial inefficiency, the evidence of social maladaptation, and the evidence of antisocial conduct. Special attention is also paid to the patient's conduct while under observation, his truthfulness, his amenability to discipline, and his relationship to the other patients.

In the differential diagnosis, the conditions that demand most urgent consideration are constitutional psychopathic state, constitutional inferiority, mental deficiency, psychasthenia, and hysteria. The first two might be more properly considered subdivisions of constitutional psychopathic inferiority, yet since they occur as definite, separate diagnostic designations in the nomenclature of the United States Public Health Service, the following differentiations or special characteristics are emphasized:

Constitutional psychopathic state is differentiated by the presence of such morbid manifestations as lie in the immediate foreground of insanity. Paranoid trends, altered psychomoter activity, disturbances of affects are common. There is usually no history of marked industrial inefficiency or of

antisocial conduct, and what gross maladaptation is present does not extend back to early life.

In constitutional inferiority, there is evidence of incapacity in the intellectual and physical spheres as well as in volition and emotivity. The psychopath is usually of good physique and of average or superior intelligence, while a constitutional inferior has usually a poor physique and a mentality that ranges from dull normal to true mental defectiveness. His failure in life is due to chronic inaptitude. There is usually no history of antisocial conduct, though there may be of delinquencies of a minor nature. If he lies, it is in a childish manner and not with malice or criminal intent. If he steals, it is to meet his personal needs only, and not to satisfy an exaggerated notion of wealth and ease.

In mental subnormality or deficiency, we have primarily a defect in intellect that can usually be quickly identified by a psychological examination. The mentally subnormal or defective, like the constitutionally inferior, usually react in a childish manner and rarely commit grave crimes or antisocial acts. The discussion of exceptions and combinations is beyond the limits of this paper.

In psychasthenia, we have more marked aboulia, with consequent irresolution and with compulsions, obsessions, phobias, and fixed ideas. The ethical and moral sense is usually normal or even exaggerated. The conduct is good, as a rule, and there is rarely a court record. However, in some cases, where the classical symptoms of psychasthenia are not typically present, or there is a suspicion that they are assumed, the differential diagnosis from constitutional psychopathic inferiority of the inadequate type may be exceedingly difficult.

In hysteria, also, the differentiation may be very difficult. The industrial efficiency is usually better in the hysteric and there is seldom a history of antisocial acts. The hysterical stigmata, such as anæsthesias, paræsthesias, paralyses, hypersuggestibility, seizures, and the like, are diagnostic when typical. Psychopathic malingerers can and do simulate these symptoms perfectly at times. Not infrequently we have cases that represent a mixture of constitutional psychopathic inferiority and hysteria which we variously diagnose, for

want of a better term, as "hard-headed hysterics", or as "hysteria with psychopathic tendencies", and as "constitutional psychopathic inferiority with hysterical manifestations".

Treatment

The treatment of constitutional psychopathic inferiority in the adult is very unsatisfactory. Their personalities are so inadequate that resolution of the conflict is often impossible. Permanent custodial care is indicated in many cases properly to protect them and society. Others may succeed temporarily or even permanently if under firm and wise guidance, especially if placed in situations to which they can adjust. Still others, who are perhaps less inadequate, find for themselves occupations or environments that hold their interest and satisfy their cravings. Not a few soldiers, sailors, traveling salesmen, peddlers, railroad men, explorers, and prospectors are sublimated hoboes. Many musicians, actors, professional boxers, and baseball players are psychopathic, and not a few poets, artists, reformers, and politicians must also be so classified. Thus many psychopaths who are pronounced misfits in one environmental setting may be eminently successful and socially very valuable in some other situation. The normal individual, on the other hand, is more versatile and can adjust fairly well to all situations.

The treatment of the psychopath, therefore, consists theoretically in choosing a vocation for him. Practically, however, vocational training as offered by the Federal Board for Vocational Training has been unsuccessful in dealing with this class of ex-service men. It is very difficult to find just the right vocation that a given psychopath should follow, and still harder to get him to attempt it. Often he has his mind set on something for which he is manifestly unfitted and in which he could not possibly succeed. Then, too, the appeal of the idleness and comfort of a hospital or an old soldiers' home, with a pension, is an impelling force directly opposed to and greater than the desire to make a *bona fide* attempt at self-rehabilitation.

In children, however, the outlook is much more favorable. The gratifying success of the juvenile courts and psychiatric

out-patient clinics with delinquent and maladjusted children has pointed the way to a partial solution of the problem. But even among children, many failures are inevitable. Adler[1] states that in Illinois the courts send to the reformatories only those children whom they have failed to reform, in "a last desperate hope" that these institutions may be able to reach them. In this, he says, they are rarely successful, and he goes on to plead for a more careful scientific study of this "junk pile". This is important, but it would seem that Richards[2], Kenworthy[3], and others in similar work, who are laboring with younger children, are more apt to succeed. If we can attack what Salmon[4] aptly calls "the habit of delinquency" at its very beginning and teach parents the importance of rational training for their children, we will be striking at the root of the evil.

Conclusions

To summarize, the following conclusions seem warranted:

1. The concept of constitutional psychopathic inferiority is not clearly expressed in the literature.

2. The intensive study of fifty psychopaths has led to the formation of a working definition from the psychogenic and behavioristic points of view, and to a tentative classification into types.

3. A statistical study of the case records is presented which includes evidence that military service greatly decreased industrial efficiency and led to prolonged hospitalization.

4. Treatment of the adult psychopath by psychotherapy, reëducation, and hospitalization is of but little avail. Vocational guidance is theoretically indicated, but practically is usually unsuccessful. In children, the results are better than in adults if the environment can be properly modified.

[1] Adler, H. M.; *The Function of a Correctional Institution.* Mental Hygiene, October, 1921, vol. 5, pp. 778–83.

[2] Richards, E. L.; *The Rôle of Situation in Psychopathological Conditions.* Mental Hygiene, July, 1921, Vol. 5, pp. 449–67.

[3] Kenworthy, M. E.; *Extra-Medical Service in the Management of Misconduct Problems in Children.* Mental Hygiene, October, 1921, Vol. 5, pp. 724–35.

[4] See note 2, page 730.

THE CHILD AND THE HOME

An Extract from a Survey of Mental Health Conditions in a Metropolitan District

MARIANNA TAYLOR, M.D.
Boston Psychopathic Hospital

THE term health, for so long limited to the physical condition of the individual, is now coming to be recognized as involving elements that make up personality. Many individuals are unhealthy whose individual organs show no evidence of disorder. They suffer from disorders in their emotional life and in their personality, and these are just as crippling as disorders of the heart or lungs.

In making a survey of the health of the community, it is important to keep these disorders in mind, to estimate their extent, and to consider what facilities are available for their treatment and prevention. The survey of the health of a district, therefore, will include not only attention to the extent of infectious disease, malnutrition, rickets, summer diarrhea, and so forth, it will also include an estimate of the mental disorders to be found in the community. Mental disorders are not notifiable in the same way as infectious diseases, so that accurate statistics are not available. Mental disorders include not only cases so severe as to have to go to a state hospital, but milder varieties of the same forms of sickness. They include also many forms of apparent physical invalidism, the roots of which lie in the mental life of the individual. They include many forms of poor conduct which are usually judged from ethical or legal standpoints and are not thought of as medical problems—e.g., alcoholism, delinquency, prostitution, and vagrancy. They include many of the difficulties of children, whether these be due to mental defect or mental instability.

A statistical survey of this whole field would be a very complicated matter. It would, however, deal with one aspect of public health that is of very great importance, that is to a

large extent neglected and ignored, and in relation to which definite practical preventive measures may perhaps be taken. It is not possible to canvass thoroughly even a small area with regard to the prevalence of the disorders referred to above. One has not the authority to ask for the information. The community is often not especially interested in the topic. There is, as a rule, very great reluctance to admit the existence of such disorders.

To demonstrate the actual conditions, to show the presence of important disorders that are, to a large extent, neglected, advantage was taken of the already existing agencies that do health work in this community. The workers were very much interested in this new approach to health problems, and appreciated the importance of the topics under study. It was felt that the most speedy and most concrete demonstration of the situation in regard to these mental disorders would be given by reviewing groups that were already known to the existing health organizations, and by looking for conditions of mental disorder or defect. There were several sources of material for such a review. It was possible to make a slight survey of the clinical material at the local dispensary, to see whether some disorders essentially mental were not masquerading as physical disorders. It was possible to get some data with regard to the extent of delinquency. It was possible to enter a random group of homes with a district worker, and to study the conditions under which children were being brought up and the presence of any mental disorders or defects among these children and their relatives. It was possible to get some data with regard to the number of patients from this district who have suffered from mental disorders sufficiently serious to require treatment in a mental hospital. It is obvious that in a brief and necessarily superficial survey of this type only illustrative material can be obtained. The most demonstrative material obtained was that which shows the actual conditions of the children in many homes in this district. One of the most important spheres of work in the prevention of mental diseases has to do with the conditions surrounding childhood. The data obtained from these homes are presented here in a very much abbreviated

form, but from them those interested in mental hygiene can gain food for thought.

Case 1.—The A— family are Italians of the better class, living under good economic conditions, in a comfortable three-story house. The father is a real-estate agent. The family consists of father, mother, and nine children, ranging in age from sixteen years to one day. These children have intelligent parents and live under favorable hygienic conditions and in a good neighborhood, yet three show marked signs of rickets—badly bowed legs, the deformity being so pronounced as to require operative treatment. Three are high-strung and neurotic.

A—, a boy, aged seven, is rachitic. He is restless and fidgety, and at times he stutters. There are choreiform movements of his hands. He tells how the American children next door throw stones at him and call him "wop", and remarks: "We get mad on them." His sleep is disturbed by terrifying dreams of a man killing him with a knife.

B—, a girl, six years of age, still soils herself and wets her bed, despite the fact that she has an intelligent mother.

C—, a boy of three years, strikingly handsome and the spoiled pet of the family, is the most extremely bow-legged of all. He is mentally bright, but uncontrolled, and the despair of the household. He is said to be "very nervous" and stubborn and to have frequent outbursts of temper, at which times *"he will draw a knife on any one"!* He bites the other children, will not let them touch his toys, and disturbs the peace generally.

Case 2.—A. B—, aged six years, is the youngest of a large family living under fairly good conditions. She is bright mentally, in the second grade in school, but is stubborn, spoiled, and difficult. She still talks baby talk, substituting w for r. Her mother considers her a "nervous child" and meets the problem by sometimes petting her and at other times angrily spanking her and shrieking at her. As a result, the child has tantrums and is disagreeable. She tries in every way to assert her independence and rebels against authority. She has a capricious appetite, is a restless sleeper, and has

terrifying dreams. By day she is preoccupied by fantasies. She is disciplined in such a way as to increase her neurotic traits.

Case 3.—The C— family consists of father, mother, and four children, aged four, six, eight, and ten years. They are Italians, living under good economic conditions. The boy of six is ill in bed with pneumonia, and because his family have never had any control over him, it is now exceedingly difficult to handle his case, making the outlook grave. He is "nervous", rebellious, finicky about his food, and refuses his medicine. Frequent slappings do not help matters. He screams and shrieks out to his bewildered mother: "Lie down with me or I'll die!"

The girl of eight years is pale and anæmic. She revels in the distinction of having had ether twice, because of an ear condition, and ether pneumonia two years ago. "If you don't let her have her own way, she kill herself."

Case 4.—The D— family, Italian, live in six rooms. The father is a fruiterer, and there are nine bright, alert, healthy children, the oldest sixteen years old and the youngest one day. The father came over to this country when one year old and is proud of his American citizenship. Six of the children are at school and are keen and alert, and insatiable readers, each getting one book a week from the public library. The oldest boy, aged sixteen, suffers from headaches and is very nearsighted. He is "nervous", and a bookworm when he is not working. He is very ambitious and very much alive.

Elsie, aged twelve years, sagely remarks about her mother and their new baby: "It's funny she never gets a girl! Boys are devils, and she gets them."

Thomas, aged two and one-half, sits solemnly by the stove, smoking a pipe constructed out of two clothespins and reading a newspaper. The others amiably keep telling him that the new baby now has his place, and do all in their power to make him jealous and irritable and at outs with his universe. They threateningly say that the visiting lady will take him away in her bag. He looks eagerly in the bag, hoping that the nurse may have secreted the unwelcome new baby in there

preparatory to kidnaping it. (Jealousy complex artificially encouraged.)

Case 5.—The E— family are intelligent English people, who live in a comfortable two-story house. There are two little girls, aged ten and two and a half years. The older is seriously ill with a heart condition and should be kept quiet and free from excitement. The younger child is bright and irrepressible. Her mother says she is "obstinate, stubborn, and wilful". She is fidgety and exigent. Her mother naïvely attributes this entirely to the fact that she herself was ill when she was carrying the child. Little Rose commands the father to bring her home presents every night and specifies what he shall bring. They always obey her for they "feel it is wrong to promise a child something and not do it". "If you come home without her present, there is a frightful scene." Little Rose, during the visit, danced about the room, irritable and thoroughly discontented. She repeatedly shook her sister's bed and behaved like a human cyclone. Her mother looked at her proudly and said: "Say your verses for the lady and I'll give you something pretty." Rose sulked and demurred, but finally craftily gave in and repeated a number of rhymes self-consciously, after which she said: "Now give me something pretty." "Hasn't she the grand memory?" said the proud mother. "She's awful smart. Emily is just like her, but her nerves are bad, so I don't teach her elocution, but she has talent." By way of making conversation, Mrs. E— said to Rose: "The lady will take you away if you're a bad girl. Does papa love you, dear?" she continued. "No!" shrieked Rose savagely. "Does mama love you?" "Yes." In this case it was learned that all the discipline given this unfortunate child is administered by the mother, the father being "far too kind-hearted"!

Case 6.—Charles and Frank F— live in a spotless Italian home. They are imaginative children, showing ability to amuse themselves and to invent games. They are active and full of energy and initiative, and keep busily occupied. Such children have possibilities if properly trained. They are naturally mischievous and always seeking an outlet for their

emotions. In consequence of this, the misguided parents scream at them to keep them quiet, but never either expect or enforce obedience. Like a whirlwind, the elders rush into the kitchen and pounce down upon imitation houses made of soap boxes, snatch them away, and shriek, calling the young pirates "bad boy" and "dirty" because they disarrange the kitchen. The play life is repressed as far as possible. The elder boy, aged three, has a stormy temper and is constantly fighting with the younger child, has a finicky appetite, and is underweight. He sucked his thumb until recently, but was cured of this habit by his mother's burning the thumb on a red-hot stove. The younger child, when he becomes a little boisterous in his play, is forcibly and roughly set down like a bag of meal on a chair. This treatment makes him cry rebelliously; whereupon a crust of bread is thrust into his mouth as a pacifier and silencer. This child, aged twenty months, does not yet talk beyond saying "papa" and "mama".

Case 7.—The G— family are Americans, living in squalor in three dark rooms. The father is a longshoreman; the mother has just been delivered of her sixth child. Three of the children are undernourished and anæmic and coughing constantly. All lack initiative, and are shy, silent, and inert. They look as if they had never smiled. They are utterly unresponsive. They are said to be "very good and to give no trouble". The three-year-old is evidently mentally retarded and apparently has defective eyesight. She is slow and dreamy.

Such a family as this need very special care and insight. The outlook at best is but poor, yet with better hygiene these children may be self-supporting as adults instead of a burden upon the state, as they bid fair to be if present conditions are not improved.

Case 8.—The one saving thing in the previous household was the arrival of Mary H—, who lives in the tenement upstairs. She reads to the lifeless G— children. Mary is a talkative, aggressive child of eleven years, eager to tell all about her family. She says she is "nervous" and that she

dreams and cries out in her sleep. She bites her nails, especially when she reads in school. "Mother hollers and scolds and tries to stop me, but I can't stop."

Her younger sister Martha is ten years old, and "she is always daydreaming. She sits still and never says a word, and then all of a sudden says: 'I dreamed——' And then she tells a long make-believe dream."

Robert, aged four, has "terrible tantrums". He has a frightful temper and pulls out his sisters' hair. He smashes up things generally, but the youngest, aged two, "is good and plays by himself all day".

Case 9.—The I— family are Italians in good circumstances and live in a sunny house fitted out with conveniences and nicely furnished. The mother is a buxom, showy type of girl, pleasant, but unreliable. She has a boy of four, a girl of two, and an infant two days old. The children are fat and sturdy. The mother talks about her children amiably, and their traits give her no concern. The little boy (he was late in talking and walked at thirteen months) she says "is so bold". "He throws the little girl down and fights her. He talks in his sleep and bites his nails." He doesn't mind, so his mother gets him out of her sight by turning him over to her relations, "because he makes her so nervous", and "they have a terrible time with him over there". He kicks and gets red and has brain storms, and bites other boys on the back. The family beat him, "but he does things just the same. He wants to have his own way, don't you know." *And he gets it!*

Case 10.—The four J— brothers, with their wives and children, live in one house, under fair economic conditions. The four cousins, three of them named Alice, play together.

One of these little girls, aged two, an only child, her mother describes affectionately as "a mean child who fights everybody". She cries if her mother leaves her for an instant. "She is her mother's baby." And so the mother never does leave her, and pets her and makes her more and more of an *enfant terrible.*

The children of these families, despite the fact that they are

called "fresh" and "bad" and "mean", are happy, normal, and in excellent physical condition. They are wisely fed, eat well, and sleep well. They have plenty of fresh milk to drink and are given cod-liver oil in addition.

The father of two of them has an unusually intelligent attitude toward their play life. In consequence, they are thoroughly happy and romp to their hearts' content, making all the noise possible. As he observes, it is a good thing there is no one living beneath them, for other tenants would not stand for such a bedlam. The little youngsters of twenty-six months and two years lie side by side on the bare kitchen floor on their backs and kick furiously, making a great noise with their new shoes on the wooden boards. Better exercise could not be prescribed to make them strong and to keep their bodily functions normal. When exhausted by this strenuous play, they get up and ride on their rocking-horses. This was one of the few families that had just been visited by Santa Claus—*the first home in this series in which there were toys of any description.*

Case 11.—The K— family consists of father, mother, and five children, aged ten, six, five (twins), and two years. All the children but the youngest attend school and kindergarten. The atmosphere of this home suggests that even among Italians quiet and patient training brings the desired results. These children are "good", under excellent discipline, and yet alert, normal, and active. No neurotic traits present themselves. The children play happily together and voluntarily help their mother with the housework. She is a gentle type of woman who does not correct them in a noisy fashion. She is a hard worker, scrubs the bare floor every day, and keeps the house as presentable as possible. The children are a real help to her of their own free will. This was the only home in which an atmosphere of this sort was found.

Case 12.—The L— family live in squalid conditions in three dark, dingy rooms, devoid of sunshine or ventilation. The father is a laborer. There are four children—seven, five, three, and one. The oldest masturbates frequently and is mentally retarded. The mother is resigned to the situation and no attention is paid to the child's habits.

Case 13.—M— is a tailor by trade, living in a comfortable four-room flat. The children range in age from ten years to two days. Emily, the eldest, a thin, owllike child with big glasses and a self-righteous bearing, is a chronic tale-bearer, which accomplishment raises her to a high place in the esteem of her parents. She only too readily launches forth into an enthusiastic rehearsal of the misdemeanors of her "fresh" brothers and sisters. She is a pale, anæmic-looking girl, undernourished and restless. Every one "picks on her"—with good reason. "The boys steal her pencils at school, and she tells on them and the teacher hits them." She constantly twists the buttons of her sweater between her long, thin fingers, she bites her nails, and she is a bed-wetter. She gives a history of having had a vaginal discharge a year ago and sore eyes. Her strong suit is "squealing on" the others to her parents, and she finds plenty to squeal about. When she squeals, her parents belabor the offender whose sins she discloses while she sits by a paragon of virtue, and gets off scot free. She usually tells tales on Remus because he punches her. Then Remus receives a parental punching which incites him again to punch the tattle-tale, and so the vicious circle goes. Emily is a noncombatant herself, knowing that if she fights, she will get not only worsted, but "squealed on", and then her father will hit her. She gets her satisfaction indirectly, with safety to herself, whereas Remus does his own pummeling and suffers the consequences unflinchingly. He is a wide-awake, attractive boy of six years. He not only is an untiring fighter and given to tantrums, but he talks in his sleep. He is "a fresh boy at home, but he be's a good boy at school".

His sister, eight years of age, stayed in one class two years. "She was always afraid teacher would hit her if she was absent. She doesn't want to do no work and mother hits her." A visiting neighbor observed: "Believe me, they have a good mother. She lets them have all their own way and that doesn't pay." The mother has absolutely no influence over this family.

Julia, aged four and a half, has a finicky appetite, and bites the others. She is irrepressible and self-conscious,

tends to be dramatic, makes silly faces, and is full of spirit and fun; her father calls her "crazy".

The boy of three years picks his nose continually, is a mouth-breather, and has adenoids.

All of these children are said to be timid if any one knocks at the door, and they run away from a chicken in a panic of fear!

Case 14.—Mr. and Mrs. N— and their two children of two and three years live in a spotless flat under good economic conditions. The little girls are perfect specimens physically. The older one is "nervous". "If she don't get her own way, she gets awful bad!" She consequently always manages to have her own way in everything and is never crossed or disciplined. The demoralizing factor is an indulgent grandmother with whom this child sleeps and who grants her every wish. The younger child "is never any trouble". "She sleeps with her mother and doesn't get everything she wants."

Case 15.—The O— family consists of father, mother, and three children. The father is a noisy, bombastic individual, excessively talkative and high-strung, always ordering his family about. He is egotistical, feels his importance and responsibility, and keeps everything in an uproar. His wife remarked drearily: "Isn't he something awful? He's like this all the time when he's home. He talks all the time and makes me nervous." The oldest child, a girl of eight years, grits her teeth at night. The boy, aged four, twitches his eyes, has "terrible tantrums", is "backward", a mouth-breather, and has adenoids. "If he don't have things his own way, it's wicked around here. He's spoiled!"

Case 16.—The P— family is an illustration of a household in which the mother is an ineffectual, negative sort of individual, a helpless type. The children are utterly undisciplined and there is constant confusion. There are six of them in all, ranging from ten years to eight months. The ten-year-old bites her nails, and the eight-year-old boy hits the others, swears, and calls them all "blind". He fights continually and misbehaves in school.

The seven-year-old boy has been two years in one grade.

Case 17.—The Q— family live in three rooms under fairly good economic conditions. The father is a longshoreman. Of the three children, aged six, four, and two years, two are strong, but the four-year-old boy has been ill from infancy. He had a difficult instrumental birth, and at nine months began to have convulsions. These have increased steadily in severity and frequency, and at present he often has seizures of several hours duration and many slight ones, both day and night. He has had no other illnesses, but is developing an unusually slow pulse and an interesting heart condition. He is given solicitous care and is never disciplined. He is pale, thin, and restless, and shows many neurotic traits. He runs away whenever he gets a chance, and will not obey his parents or answer when spoken to. He is mischievous and has a violent temper. He bites his nails, picks his nose, grinds his teeth, and masturbates. He is constipated and has difficult urination with flushing of the face, and is losing weight. He has never talked plainly.

Case 18.—Mr. R—, an Italian laborer, has six children, ranging from ten years to ten months. They are all "nervous", and their maternal grandmother and aunt have been insane. All of these children have been slow in developing; none has talked before two and a half years. One has been in one class two years at school. The three aged five, three, and two are "always wet". The two-year-old also soils himself. He is a restless sleeper, and rickety and bow-legged. He "eats all the time", goes from house to house—his aunt's, grandmother's, etc., nearby—and is fed all day long by well-meaning relatives. As regards masturbation, the aunt said: "They all do it, you know. You can't watch them. We holler at them."

Three weeks ago, the five-year-old child set herself on fire with a candle and was seriously burned. The mother, believing that the child would surely die, was frantic with grief; she developed delusions, refused to eat, and finally became maniacal and had to be committed to a hospital for mental disease, where she died within two weeks. Some of these children will probably be placed in institutions.

Case 19.—Alexander S—, a boy of nineteen years, illustrates the effect of lack of training. His mother is an excitable woman with a hot temper. Alexander was the first child and was from infancy "nervous and irritable". He "cried easily and wanted everything his own way". He was threatened and shrieked at, but was not controlled. (Babies are too often at first petted excessively and "spoiled" in every conceivable way, and then beaten and ineffectually scolded throughout later childhood. Many parents seem to know no other method of discipline.) Alexander attended school as far as the eighth grade; then refused to finish because, as he explains, "he thought he was a man and wanted to go to work". Now he shows lack of ambition, is lazy, and usually out of a job. His mother says he refuses to work and has a bad temper. He has never learned to make an effort to apply himself to anything long or to feel any degree of responsibility.

Case 20.—The T— family consists of father, mother, and three children, the eldest a girl of nine years and the youngest a seven-months baby one week old. They live in four rooms, and the house is neat and clean. The father is a blacksmith, but is out of work. His manner toward his wife is sullen, vindictive, and domineering. When she started to tell about her fall, which brought on this confinement, he ordered her to "shut up", in a suspicious fashion. He later began to talk about himself and said that he had returned six months ago from the Psychopathic Hospital, where he had been a patient for eighteen months. He had previously been out of work for several months, had started to loaf and worry, and then had lost his mind. He became violent, broke up the furniture and china, and beat his wife and children. His wife is thin, pale, haggard, and anxious. He never leaves the room when visitors come to investigate this home. The oldest child shows neurotic symptoms and is pale and undernourished. She has had diphtheria, scarlet fever, and operations on her ear and throat. She is in the third grade at school and is morbidly anxious to be on time, to such an extent that every night she changes her clothes and puts on clean ones in which she sleeps, in

order to be punctual the following morning. She is finicky about her food and excessively fussy. The four-year-old boy had convulsions three times a year ago.

If the father wishes to enforce obedience from his children, he raises a chair and threatens to hit them over the head with it, and would probably carry out this threat. His tone, when he speaks of his wife, is one of contempt and hatred. The wife is ignorant and uncoöperative and refuses to allow her husband to be placed in an institution.

Case 21.—The U— family consists of four girls and one boy, ranging from nine years to four months. The eldest is "nervous", bites her nails, talks in her sleep, and picks her nose. Both she and her eight-year-old sister have been two years in one grade at school.

The next two children are bed-wetters and have incontinence of urine in the daytime as well. No effort is made to correct these conditions.

Case 22.—The V— family live under fairly good conditions. The father is a chauffeur. There are five living children, aged twelve, seven, six, four years, and two months. Of these the seven-year-old girl has incontinence of urine. The six-year-old boy is called "fresh", which means that he is mischievous and uncontrolled and annoys the other children. He picks his lips and nose, sucks his thumb, and is a mouth-breather. He does not talk plainly. The four-year-old girl also picks her nose a great deal of the time. These neurotic trends are blandly taken for granted. Occasionally spasmodic efforts are made to correct them. The children are slapped or screamed at, but it is not expected that they will obey, and they simply become more rebellious and nervous in consequence of such ignorant measures.

Case 23.—The W— family live under very crowded conditions. Alice, Emily, Julia, and Thomas, aged ten, eight, seven, and five, sleep in one bed. Thomas is bright mentally and talks well, but cannot walk and has hydrocephalus. He had meningitis when six months old. Emily has tantrums, screams, and hits the others. The sixteen-months-old child is deformed from rickets.

Case 24.—The X— family live under poor economic conditions. There are five children. The fourteen-year-old girl sleeps in the same bed with her brothers, aged eight and five years. Two of the children are cross-eyed and one is "nervous". He is a mouth-breather and cannot talk plainly. He keeps his fingers in his mouth, and he scratches and swears on the slightest provocation.

Case 25.—Emily Y—, aged two years, is a neurotic child. She sleeps poorly, and has incontinence of urine. She has a finicky appetite, picks her nose and her fingers, and has frequent outbursts of temper, when she lies on the floor and kicks and tears her hair. Her mother meets this condition as it is usually met, not by trying to understand the child, but by soundly spanking her, flying into a passion herself.

Case 26.—The Z— family illustrates the effects that ignorant methods of disciplining have upon children. Mr. and Mrs. Z— have eight children, ranging from fifteen years to five months. The fifteen-year-old boy still suffers from bed-wetting, the five-year-old bites her nails, and the three-year-old keeps her thumb in her mouth. She frequently attacks her older sister with the butcher knife. Then the mother screams at them and threatens to take them to the hospital.

The sixteen-year-old daughter recently ran off and married a man much older than she. Her explanation of this is that from early childhood her mother beat her and never allowed her to go out. She does not want to see her mother any more and does not speak to her, but is sorry to leave her father, who cries every day because she refuses to come home.

Case 27.—A— B— has seven children. They live closely crowded, under poor hygienic conditions. The father has been away from work for two months, because of an injury to his back, and the family expenses have been met by the overseers of the poor.

The eldest child, a girl of twelve years, has always been "nervous" and anæmic. She is constantly complaining of pains in various parts of her body, especially severe headaches which are not relieved by glasses. She has remained two

years in one grade in school. She is constipated and has a finicky appetite and a bad temper. She cries easily upon little or no apparent provocation, twitches her eyes, and bites her nails, and her sleep is disturbed by distressing dreams that she is sick, is falling down from a great height, etc. The boy of thirteen also frequently twitches his eyes and is constipated.

A younger brother, aged ten, has, like his elder sister, remained two years in one class.

One other child talks in her sleep, and one is cross-eyed and wets and soils himself.

Case 28.—C— lives with his wife and five children in three small, dirty rooms. The wife is subnormal mentally. She is unable to tell what grades her children are in, saying, by way of excuse, that she "forgets everything they say". She says she "gets so nervous" she'd "like to kill them", and gets "so mad at times that she faints". The children "fight like cats and dogs"—especially W—, aged nine. Her mother, enraged, hits her on the head with a stove brush. This child cannot speak plainly, still wets her bed, and talks in her sleep, as does her younger sister, aged eight. The five-year-old is "nervous and cranky". "If she wants something and doesn't get it, she cries the whole day long." The mother shrieks at the children intermittently, "Stop! This lady'll hit you!" One of the children in this household died at thirteen months of convulsions, and the youngest, aged nine months, is restless and twitches in her sleep.

Case 29.—C— D—, aged seven, is cross-eyed and has failed to be promoted in school because he "could not learn".

Case 30.—E—, aged four years, cannot speak beyond saying "mama". He has had seven operations on neck, throat, ear, and spine. He is not defective mentally, but is "nervous", "must have his own way", and is subject to temper tantrums.

Case 31.—Mrs. F— complains that her boy of four is "fresh" and uncontrollable. He is saucy and has outbursts of

temper in which he bites and kicks people. He is a mouth-breather and bites his nails. His mother exclaimed: "Another woman would have killed this kid long ago. *I hit him terrible!* He deserves to be killed! He can't stay still. He's got to be doing something. He breaks the furniture and everything." Not only is this boy uncontrolled, irrepressible, fidgety, and inquisitive, but his sister, aged two, is likewise getting "fresh". The father is "awfully hot-headed" and does not answer when spoken to, if irritated. His wife is "nervous" and explosive.

Case 32.—The G— family live under good economic conditions, in four rooms. The mother is a good housekeeper. There are six children, ranging from nine years to thirteen months. This home shows the most normal atmosphere of any yet visited. The mother attributes the good behavior of the children to the fact that she herself is not nervous and does not lose her temper or beat the children. She has observed that in homes in which the parents bully their children there is always less obedience. Also, she never represses the children's play life. They amuse themselves well, and when she goes out, she leaves them playing school together and they never make any trouble. They are bright, alert children, full of initiative and imagination. The hygiene of the home is better than is often found. The three oldest girls sleep together in one room, and the two smallest have separate beds in their parents' room. One child is cross-eyed, and the mother is careful to see that she wears her glasses to correct this. Three of the children attend school. One was given a prize for having dental work that had been advised by the school physician done promptly. These children are free from neurotic trends.

Case 33.—H— is an only child of four years, much pampered and spoiled. The home conditions are poor, two families sharing four untidy rooms. The child's father, a laborer, has been out of work for two months. The child's mother is said to be high-strung and to have a hot temper. The little girl is never still. She is fidgety and restless and irrepressible. No one has any control over her. When not

given her own way, she flies into a fit of anger, lies on the floor, kicks, screams, bites and scratches, and tears her hair. The doctor has advised them not to notice her, but just to let her have her own way, and predicts that when she is ten years old, this condition will clear up! This child has a capricious appetite and, never being disciplined or trained, she is consequently underfed and undernourished. She runs away constantly, and she both soils and wets herself by day and by night.

Case 34.—Mrs. I— is a high-strung, nervous little woman, a widow, who lives with her three children in a tenement of three rooms. The older children, aged eight and five, are "no trouble", but the three-year-old girl "drives her mother crazy" because of her tantrums and her restlessness. Yet when this child is away from home, she is invariably well-behaved and obedient. In the day nursery she is a model child, and when she was sent away to the country last summer, she gained weight and had perfect health. At home she presents a very different picture. She is undernourished, excitable, and uncontrolled. She "shivers" and twitches her eyes. At times she is said to have "convulsions with fever". She continually bites her nails and picks at her nose and lips. When she goes to sleep, she does so with the lace curtains between her teeth. She sleeps with her mother because she refuses to sleep alone. She comes as near to perpetual motion as one could find anywhere; it seems impossible for her to stay still. She grabs things away from the other children, then plays with the toys for a brief time, but shortly destroys them, tearing them to bits. She opens the icebox, throwing the food out on the floor. "When she's got to do it, she's got to do it." She lies on the floor, kicks and screams, and chews bits of string, pulling them back and forth between her teeth. "Her mother licks her", said her aunt, "but it makes her worse." The distracted, thin, frail mother is at her wits' end with this child, failing to understand her or her needs. If she tries to do her ironing, the child in a rebellious temper snatches away the clothes, clings to her dress, and makes a disturbance in every conceivable way. "Her mother punishes her every minute—*she's got to.* Then she tries petting

her, but nothing does any good." Gentle firmness she has no conception of. The child is absolutely untrained and still wets her bed. Much of her nervousness has been attributed to her adenoids and tonsils, which should be removed. The delicate and baffled mother is constantly begging various agencies to place this child for her, her one solution seeming to be to get the girl adopted and thus disposed of.

Case 35.—J—, aged two years, jumps whenever he is spoken to. His mother excuses his nervousness by saying, "He wants everything his own way. He is the first child, and they are always spoiled, you know." He has a finicky appetite and is much underweight. He bites his nails, picks his nose, and has tantrums on the slightest provocation. He wets himself continually and is a restless sleeper, often crying out through the night.

Case 36.—K—, an American child of four years, is an illustration of what wise training accomplishes in a nervous child. This child bites her nails occasionally, has a finicky appetite, and talks in her sleep if she has been the least excited before going to bed. She used to have frequent severe tantrums. At first the mother would lose her temper and fly off the handle, she says; whereupon she found that the child got just like *her,* and matters went from bad to worse. This mother found that by coaxing the child, and diverting her attention, she had no difficulty in controlling her. Though naturally a nervous, high-strung woman, she has worked out this method herself and has adhered to it. The child now goes to kindergarten and is one of the brightest and best trained of the children. She learns quickly and seldom has to be corrected or spoken to.

Case 37.—Elsie L—, aged four and a half, is a neurotic child. She picks her nose, bites her lips, and picks at things with her restless fingers, and twitches her arms and legs occasionally. She is a finicky eater, and refuses to go outdoors and play, preferring to sit near the stove with her dolls. She is a dreamy, preoccupied, sensitive child who does not answer when spoken to, a case in need of special supervision and

care. She is a restless sleeper, jumps, twitches, and talks in her sleep. She wets her bed, and a doctor, consulted casually, remarked that it was her kidneys and advised that they be kept warm. This nervous child is attending school, and no one has given her physical or nervous condition the consideration it demands.

Case 38.—Mrs. M— is a very nervous, sensitive woman. She has four children, aged seven, six, four years, and eight months. The boy of six years is likewise "nervous", and twitches. He talks in his sleep, and has mad outbursts of temper. The four-year-old girl is very much like him, and in addition she wets herself and is excessively shy. All three children bite their nails and pick their noses and lips.

Case 39.—In one kindergarten visited, fourteen children were present out of an enrollment of forty. Of these fourteen, three showed marked neurotic trends. One, a boy of four, when first brought to school, was restless and intractable; he rocked back and forth constantly, and screamed a large part of the time for two or three days. His father brought him each day, and roughly "yanked him about and cuffed him". After three days, under a different type of treatment, this child became quiet and happy.

Another boy of four years is reported to be dreamy and inattentive and listless. He follows his brother about and imitates everything he does.

One child, five years of age, the teachers say is "spoiled". He will not listen, is disobedient and indifferent. He is subject to frequent outbursts of temper and no method of discipline seems effectual except terrifying and bullying him, the procedure to which he is accustomed at home.

Case 40.—There are seven children in the N— family. Four of the seven are nervous, three of them bite their nails or lips a large part of the time, one cries out in her sleep, and the boy of twelve is "fresh" and continually fighting with the rest.

Case 41.—Mrs. O— is a mild, ineffectual, gentle sort of woman who has little influence over her seven children. Her

husband, on the contrary, is intelligent and coöperative. The boy and girl of four and five years do not yet talk plainly, and the girl of eight years still wets herself both during the day and night. The teacher meets this condition by sending the child home from school as a method of punishment, and in consequence she has remained two years in one class. The father willingly consents to take the child to a nervous clinic for examination and advice, and welcomes assistance of any kind.

Case 42.—There are eleven children in the P— family. The eldest, a girl of seventeen years, has recently had an illegitimate child. The father threatened to kill her if she returned home from the hospital with the baby, so she parted with the infant, though fond of it. Nine of her ten brothers and sisters (including three boys of fifteen, thirteen, and eleven years) still wet themselves. All five of the boys and the little girl of four have violent tantrums. The little girl "cries for everything and gets it". "She dances about, trembles from head to foot, lies down on the floor, and shrieks." She also sighs and walks in her sleep. The fifteen-year-old boy is the special despair of his mother. He has reached only the fifth grade in school, and his mother says she "wants to put him away for she thinks there is something wrong with him". "The more she whips him, the worse he behaves." His oldest sister also was two years in one class, and left school at the age of fourteen when she had reached the seventh grade. All the children pick their noses and bite their lips and nails.

Case 43.—The Q— family history is a tragic one. Mrs. Q— went to work in Italy when but eight years of age. Her mother had died three years before this, and her father was alcoholic and abusive. Mrs. Q— has had a family of seven children, ranging at present from nine years to six weeks in age. She has lost three of the seven. Two of them, boys of one and two years, were *feebleminded*. A girl of six is feebleminded and is at present in an institution. The girl of four years shows marked deformity from rickets, and is a mouth-breather. She also is probably subnormal mentally. But one

child, a girl aged eight, is bright and normal and doing well in the second grade in school.

Case 44.—Annie R— is eighteen months old and an illegitimate child. She is intensely nervous. Her mother, in desperation, "threatens to kill her twice a day". The baby wets herself day and night, sighs in her sleep, and possibly has slight convulsions. Her hand is never out of her mouth; she is constantly chewing it. She has many tantrums every day. She shivers from head to foot and holds her breath until she is blue and exhausted.

Case 45.—Mrs. S— is epileptic and "gets mad and beats her four children". She is much of the time out on the streets, leaving the house locked and the child of five in charge of the two younger ones. The oldest of the four, a boy of six years, has been two years in one grade "because he wets himself". This is not the actual reason, for he is mentally retarded, is slow to answer, and does not yet speak clearly. He is a finicky eater, and thin and undernourished. His five-year-old sister sleeps poorly and has had convulsions. These children are under the care of an utterly irresponsible mother.

Case 46.—Mrs. T— is the mother of eleven children. She is mentally subnormal. Her husband, a longshoreman, is a steady worker as a rule, but owing to present economic conditions has been out of work all this winter and last.

The boy next to the oldest, aged seventeen years, is deaf and dumb and mentally deficient. He is in an institution for the feebleminded, but comes home on occasional visits. He behaves well for a time, but after a few days gives way to outbursts of temper, and threatens the life of his parents. It becomes necessary to call in the police, and it takes three or four men to control him. Despite this fact, the mother regrets that he is not at home permanently. He is especially sullen because he is not given all the money he wants. Several of the other children show nervous and mental abnormalities. Three of them have been two years in one grade at school; one has been repeatedly punished for truancy. The boy of eleven is a mouth-breather; the girl of seven wets herself both night and day, and twitches her eyes; the little five-

year-old girl did not talk until four years of age and has marked facial asymmetry; and the boy of two years has convulsions.

Case 47.—Mrs. U—, a woman of thirty years, is subject to frequent hysterical episodes. She has had six children, three of whom are living. She divorced her first husband and subsequently had an illegitimate child, now five years of age. Two years ago she married a second time.

The five-year-old child talks in her sleep, and an older girl, aged seven years, remained two years in one class.

This woman spends a great part of her time in bed. She is torn by mental conflicts of a religious nature, and lives in constant fear that the end of the world is impending. She has labored for some time under a delusion that she is pregnant and two months overdue.

Case 48.—Mrs. V— is an excitable, high-strung American woman. She lives under poor economic conditions, is a widow, and supports her two children by working in a factory. The older child, aged four, is diffident and seclusive. She talks and plays spasmodically, and shows little interest in the other children in the day nursery. She is not a good mixer except with grown-ups, is stubborn, lacking in energy, and refuses to attend kindergarten.

The younger child, aged one year, does not try to walk, has a finicky appetite, and wets herself. She was brought to the day nursery, but cried continually for three days, and has since then been kept at home under the care of the grandmother.

Case 49.—Mrs. W—, a nervous high-strung little American woman, brought her three children, aged four years, two years, and seven months, to the clinic. She states that they drive her wild; she cannot control them, and frequently is so nervous that she does not know what to do and is obsessed with the desire to throw them all out of the window.

The oldest, a boy of four, is clumsy and always falling down. She has no control over him. He has frequent outbursts of temper. He bites his nails, picks his nose, and masturbates.

The next child is a puny, pale, tiny girl of two years, markedly undernourished. She has a finicky appetite and an

irascible temper. She sleeps poorly, wets herself, bites her nails, and masturbates. She does not yet talk. Her brother is sturdy and strong, is always picking on her and teasing her.

The baby also is undernourished.

In a series of 190 children the following conditions were found:

1. *Speech defects*	
Baby talk	10
Stuttering	1
Late in talking	4
Mutism	2
2. *Motor habits, incoördination, and convulsive manifestations*	
Fidgetiness and choreiform movements	13
Twitching of eyes and face	7
Shivering	2
3. *Incontinence, etc.*	
Bed wetting	49
Incontinence by day	27
Soiling	9
Difficult micturition	1
4. *Conduct defects*	
Holding of breath	1
Tantrums	52
Spoiled child (stubborn, difficult, uncontrolled)	41
Excessive boldness	11
Excessive timidity and shyness	13
Excessive finickiness and precision	1
Running away	3
Truancy	2
Pilfering	1
Biting and scratching others	5
Seclusiveness	6
5. *Sleep disturbances*	
Restless sleep	12
Disturbing dreams	7
Sleep walking	1
Crying out in sleep	6
Sighing in sleep	2
Talking in sleep	11
6. *Mental habits and mental grades*	
Mentally retarded or defective	13
In one grade two years	18
Given to daydreaming and fantasying	3
Preoccupied and absent-minded	4
Epilepsy	3
Idiocy	4
Mentally deficient, epileptic, or psychotic parents	18

7. *Miscellaneous*

Capricious appetite	17
Headaches	2
Imitativeness (excessive)	1
Masturbation	12
Thumb and finger sucking	10
Nail biting	33
Picking of nose, lips, and fingers	26
Gritting of teeth	3
Strabismus	10
Excessive jealousy	2
Hydrocephalus	2

Difficulties in personal balance, if not mental problems, sometimes express themselves in various substitutive forms. In some cases such difficulties are at the basis of alcoholism. As illustrative of the actual situations in which alcoholism plays an important part, the following cases are cited:

Sex	Age	Economic condition of home	Heredity	Other data
G.	14	Poor, dirty, and overcrowded.	Parents ex-alcoholic. Father lazy. Mother "a chronic beggar". Brother feebleminded and delinquent. Two sisters delinquent, one living at home with two illegitimate children.	Feebleminded and immoral (mental age 8 years; I.Q. 57). Mother refuses to place child in institution.
G.	14	Filthy. Hygiene poor. Improper and insufficient food.	Father and stepmother alcoholic and abusive. Children 14–10, bed-wetters.	School record very poor. Unhappy and overworked at home.
B.	12	Poor.	Father alcoholic; court record (stealing, nonsupport, assault and battery). Mother abusive. Maternal grandparents alcoholic. One maternal aunt epileptic and two mentally deficient.	Mentally retarded (mental age 8 10-12; I. Q. 68). Nervous, disobedient, seclusive, timid, and irritable. Bad company.
G.	18		Father alcoholic. Stepmother immoral, and mother reputed to have been.	Mentally retarded (mental age 10 6–12; I. Q. 66). Syphilitic. Sex delinquent. Industrious factory worker.
G.	17	Home filthy during mother's life. Improved recently.	Father colored, alcoholic. Mother, French Canadian, died recently; was abusive and immoral. Family mentally subnormal. One child stutters. All stubborn and unmanageable.	Mentally retarded. Speech defect. Truancy.

The total number of juvenile delinquents placed on probation last year in the probation court for all Boston was 849. Of these 107 came from the district under consideration.

In 1921, the S. P. C. C. handled 100 cases living in the district studied out of a total of 1,507 cases in all Suffolk County.

Such cases as the following may be mentioned in an ordinary sociological or economic review, but tend to receive little attention from the point of view of the basal psychological factors:

Sex	Age	Economic condition of home	Heredity	Other data
B.	13	Child boarded out in objectionable homes.	Parents separated. Father tuberculous. Mother served term in house of correction.	Feebleminded (mental age 8 4–12; I. Q. 62). Has sold papers from 9 years of age. Sensitive, bed-wetter, tantrums. Runs away from foster homes.
G.	15	Good.	Father dead (tuberculosis). Mother rigid disciplinarian.	Repeated truancy (mental age 13 7–12; I. Q. 87). Pathetic, tired, unhappy. Ran away from home.
B.	9	Good.	Others of family normal.	Retarded in school (mental age 8; I. Q. 83). Truant and runaway since 3rd year. Lying, pilfering, and bad companions. Masturbator. Seclusive, irritable, timid.
G.	15	Home atmosphere intolerable.	Father severe and abusive. Mother mentally abnormal. Brutal and bites child. Two children have run away. One deserted her family and is immoral.	Mentally retarded (mental age 11 9–12; I. Q. 76). Sex delinquencies.
G.	22		Unmarried, feebleminded mother.	Mentally retarded (mental age 11 5–12; I. Q. 71). Tuberculous. Sex delinquent (has illegitimate child). Prevaricator. Industrially inefficient.
B.	15	Dirty and overcrowded. Father and two boys share one bed; four girls share the other.	Father, widower, neglects and abuses children. Two mentally retarded. Boy, aged 13, delinquent (truancy, runaway, pilfering, breaking and entering, etc.).	Wayward boy. (Delinquencies: truancy, runaway, pilfering.) Refuses to attend school or go to work.

The following cases exemplify poor economic environments for children, probably determined by essentially mental factors—inefficiency, instability, or other qualities in the parents:

Sex	Age	Economic condition of home	Heredity	Other data
G.	2	Poor, but clean.	Father unstable; deserted and arrested for nonsupport. Mother poorly balanced and abusive.	Child has been boarded out; is poorly cared for and afraid of foster mother.
B.	12	Poor, dirty. Children insufficiently clothed.	Father poor provider. Mother brutal. Both parents quarrelsome and abusive. Brother delinquent.	Misdemeanors: truancy, staying out all night. Bad companions. Inveterate smoking.
B.	2	Very poor, but clean. Father scissors grinder. Lazy, erratic about work, contributes 50–60 cents a week toward support of home.	Father irritable, threatens to kill wife, terrifies children. Three paternal uncles eccentric.	Mentally retarded, uncontrolled temper. Poor physique.
B.	5	Poor. Father organ grinder. Irregular work. Income 60–75 cents a day.	Father abusive. Mother epileptic. Eight children, oldest slow to develop. Two truants.	Puny child. Unruly and uncontrolled. Bites his mother. Keeps family awake at night.

The following cases are examples of homes in which one or both parents are suffering from abnormal mental conditions (mental defect or instability):

Sex	Age	Economic condition of home	Heredity	Other data
G.	11	Mother unable to support self and child without aid.	Father died of general paralysis. Mother feebleminded and syphilitic. (Mental age 8 11–12.) One child, five miscarriages.	Mentally retarded (mental age 9 11–12.) Unsupervised, untruthful, self-willed.
B.	6	Good.	Mother mentally unstable when pregnant. Destructive and violent.	Mentally retarded (mental age 5 10–12). Overactive and stubborn.
B. 10 B. 8 B. 6 B. 5 B. 2 G. 2		Poor. Father refuses to work more than half time.	Father mentally deficient. Married to his niece. Mother feebleminded and syphilitic. (Mental age 8 1–2.)	Six children feebleminded; four in institutions.

While this report is in no sense statistical or exhaustive, it brings forward facts of great social and economic importance. Do not such findings as the above point to the need for a well-thought-out organization of the community resources for the promotion of physical and mental health? Among the steps to be taken immediately would be: (1) the establishment of mental-hygiene clinics; (2) the instruction of social workers, nurses, and parents in the simple principles of child training; (3) better recreational facilities and community supervision of the juvenile population.

CHILD MENTAL HYGIENE IN ERIE COUNTY, NEW YORK

AARON J. ROSANOFF, M.D.

Clinical Director, Kings Park State Hospital, Kings Park, New York

---

FOREWORD BY THE NATIONAL CHILD HEALTH COUNCIL.

Seven national and two state organizations, through the National Child Health Council, undertook a coöperative inquiry into child-health conditions in the rural sections and villages of Erie County, New York, during the two weeks ending December 12, 1921. This inquiry resulted from the invitation of many leading representatives of Erie County.

A most valuable contribution to this study was the information collected and the recommendations made by Dr. Aaron J. Rosanoff, who represented The National Committee for Mental Hygiene. The section on mental hygiene of the joint report was necessarily limited to data relating directly or indirectly to the rural sections and villages of the county. Therefore, the council has welcomed the independent elaboration of this section by Dr. Rosanoff, who has added other data collected by him for the entire county, including Buffalo and other cities in the county.

The National Child Health Council takes pleasure in inviting attention to this independent and more complete review of the problem of the mental health of children in Erie County as an especially worth-while contribution.

THE main purpose of this survey has been to bring to light conditions in the rural parts of Erie County pertaining to the mental hygiene of childhood. The following circumstances, however, have led to the inclusion of a consideration of facilities available in the city of Buffalo:

The total population of Erie County is 634,688 (Fourteenth United States Census, 1920). Of this total, 506,775, or 79.8 per cent, live in Buffalo. Between 85.0 and 87.5 per cent of all taxes gathered in Erie County are paid by residents of Buffalo.

Of the 127,913 residents of Erie County outside of Buffalo, no fewer than 83,710 live in the suburbs of Buffalo, for the most part within a single-trolley-fare ride. This includes the cities of Lackawanna and Tonawanda and the townships of Amherst, Cheektowaga, East Hamburg, Hamburg, Lancaster, Tonawanda, and West Seneca. The remaining 44,203 of the

population of the county are living in rural areas spread over nearly eight hundred square miles.

Even the institutions and organizations financed by the county as a whole, and not by the city of Buffalo alone, make the center of their activities in the city. Moreover, the agencies belonging to the city of Buffalo often extend their services to the rural population. Thus the city department of health does considerable bacteriological work for health officers throughout the county, makes examinations of blood, spinal fluid, and the like; the department of hospitals and dispensaries treats in its health centers and hospitals patients brought in from rural parts of the county; and occasionally a mentally defective child from a rural part of the county is placed with relatives or friends in Buffalo in order to provide for his training in a special class for atypical children in one of the city schools.

The officials and other citizens of Buffalo are accustomed to this situation. Those with whom we have conferred have invariably pointed out that a sharp separation of public activities of the city from those of the county would not be practicable and is not to be insisted upon.

This report consists of three parts. The first gives a description of county, state, city, semi-private, and private agencies within the county that have to do with child mental hygiene; the second gives an enumeration of agencies outside of Erie County that render service to children whose homes are in that county; and the third contains recommendations for such coördination of the work of existing agencies and creation of new agencies as might result in economy of labor, through avoidance of duplication, together with increase and improvement of service.

Agencies Existing Within the County

1. The *department of education* of the city of Buffalo has special provision for work with atypical children. Such work was begun in 1910, at which time there were no special classes in the Buffalo schools. Now the department conducts twenty-five such classes. At the head is a physician who has specialized in applied psychology. He occupies one of the offices of

the department in the New York Telephone Building and has two psychological assistants to help him in the work.

Children requiring psychiatric examination are referred either to the out-patient mental clinic of the Buffalo State Hospital, or to the city department of health, or to the department of hospitals and dispensaries.

It is estimated that the pupils now provided for in special classes, about 400 in number, constitute but one-third of those for whom such provision is needed. There is considerable resistance on the part of city officials, parents, and others to the establishment of special classes for atypical children and to the transfer of children to such classes. Special classes entail increased expenditure. The transfer of children to them is often objected to on the grounds that it places, at times unjustly, a permanent stigma on the child, deprives it of normal and beneficial associations, and is sometimes made in cases of normal children, hastily classified as defective merely because of a poor showing in an intelligence test or because of uninvestigated and unexplained retardation. In some instances the transfer of a pupil even to a special class for supernormals is objected to, because that, too, breaks up established associations and might force the child's ambitions and efforts beyond the limits of its capacity.

Within the department of education it is felt that these objections are relevant only in so far as the system may be abused or carelessly conducted and are based rather on fears of such abuse than on its actual occurrence. Occasional errors are probably made, and cases are cited of children who had been placed in special classes and have since eminently made good. These cases are held by some to illustrate the advantage of special classes, and by others to prove that children of good capacity are sometimes erroneously classified as defective.

The department of education considers, of course, not alone the interests of atypical children. Its advocacy of special classes is based partly on the fact that the whole school system is benefited by them through specialization of effort and simplification of problems. In the course of this survey teachers who have one or more atypical children in their classes have repeatedly reported to the investigator that these

few children occupy one-third of their time, disorganize discipline, and handicap the work with other children.

Perhaps the only true disadvantage of special classes is the sentimental one arising from the humiliation involved in the classification of a child as mentally defective. This is a sentiment that should be respected. In the past it has been needlessly irritated by the gratuitous use of derogatory expressions. There is no reason why such medical diagnoses as mental deficiency, psychopathic personality, and the like should be used in the official and published language of educational authorities with reference to any child or group of children. It is proper to speak of special classes, and in such designation should be included not only classes for mentally atypical children, but also those for the blind, deaf, crippled, tuberculous, supernormal, perhaps the "muscle-minded", and those possessing special aptitudes. It may be that, as children in the schools receive more individual attention and the work is more nicely adjusted to their special needs and capacities, a time will come when most of them will be taught in special classes of one kind or another. In that event, whatever stigma now attaches to special classes may be removed.

In connection with atypical children in the schools, a need is felt for psychiatric social workers to make home investigations and studies of family and personal histories. In some instances teachers have been detailed to do such work.

In general it would seem that the mental-hygiene activities of the Buffalo city schools are in competent hands and have made splendid progress since their organization. The educational authorities are handicapped by lack of funds and room for a complete system of special classes, lack of an adequate personnel trained for making group and individual psychometric tests and for teaching special classes, practically entire lack of psychiatric social workers, and imperfect availability of the services of a psychiatrist.

As regards the last item, it should be added that just as resistance is encountered when it is proposed to transfer a child to a special class, so there is even greater resistance when it is suggested by school authorities that a child should be sent to one of the out-patient clinics of the Buffalo State

Hospital for examination on account of suspected mental trouble.

The amount of psychiatric work there is to be done in the Buffalo schools is sufficient to justify the employment of a whole-time psychiatrist. *It should be possible to refer a child for psychiatric examination without its being taken out of the physical plant of the department of education, perhaps even without its being taken out of its own school building.*

2. In the *schools outside of the city of Buffalo* mental-hygiene activities have made little progress as yet. In the cities and larger villages with good-sized schools the authorities are attempting to make special provision for atypical children.

Among the schools visited one in Hamburg is especially noteworthy. One of its teachers has displayed an unusual interest in mental hygiene and, with the support of the principal, has equipped herself by taking special courses in psychometric work and work with atypical children. Although this school had no special class, the children who present special problems had been singled out and given a great amount of individual attention, which is even better.

In this school were found, as elsewhere, the usual handicaps of lack of room, of funds, and of an adequate personnel trained for such work.

In those parts of the county in which there are only small ungraded schools there is no such thing as mental-hygiene work. As might have been expected, in practically every schoolroom visited one or more extremely backward, troublesome, delinquent, or otherwise mentally abnormal children were found. It would be impossible to make other than a general estimate of how many additional atypical children might be discovered upon thorough investigation.

In this connection two points should be emphasized:

(a) The Lockwood Law, which provides that any school district that has ten or more markedly retarded children shall establish a special class for them, often remains a dead letter. This is because practically nowhere in the county has the exact number of atypical children for whom special classes should be provided been scientifically determined. A thorough

survey would undoubtedly reveal many school districts with ten or more such children, either in the school or in their homes. In no other way can a basis for the enforcement of the Lockwood Law in rural districts be established.

Answers to a questionnaire that was sent to all the schools reported a total of 192 children, or 1.7 per cent of the school population, retarded three years or more. The percentage, however, on the basis of total registration varied between 0.7 in one supervisory district and 2.4 in another. Retardation alone, even if fully reported, cannot be an exact basis for the selection of cases requiring special attention from the standpoint of mental hygiene.

(b) The mentally abnormal pupils in a rural school do not constitute the whole number of such children of school age residing in that district. It is likely that the most defective are precisely those who are not in the schools because of the great difficulty of managing them. In the Nassau County Survey[1] in 1916, the bulk of mentally defective children of school age were found outside of the schools. Probably the conditions in Erie County are not markedly different in this respect from those in Nassau County.

The health officer of one township reports as follows: "I know of many mentally deficient children living in this township. They have not been committed to institutions, but are cared for in their own homes. The schools are small here, and the teachers do not object to their attending; otherwise I would have to see that they were expelled from the schools."

The conditions in the rural parts of Erie County suggest the consolidation of small into larger school districts as an essential first step in the organization of mental-hygiene work there.

3. The *parochial schools* contain a large proportion of the children of the county in both urban and rural districts, as is shown in the following statistics:

Registration in Buffalo public schools	54,002
Registration in Buffalo parochial schools	about 28,000
Registration in public schools outside of Buffalo	15,075
Registration in parochial schools outside of Buffalo	about 6,000

1 *Survey of Mental Disorders in Nassau County, New York, July-October, 1916.* By A. J. Rosanoff. New York: The National Committee for Mental Hygiene, 1917. Publication 9.

A beginning has been made toward organizing mental-hygiene work in the parochial-school system, although special classes have not yet been developed either in the urban or in the rural parts of the diocese. Psychometric work has been introduced and found useful in teaching. A physician is employed who has specialized in applied psychology, and in a few instances pupils have been transferred to special classes in the city public schools by special arrangement.

Further development of this work is receiving cautious consideration on the part of the parochial-school authorities.

4. The problems pertaining to atypical children in the *orphan asylums* are similar to those in the schools, except that in all probability the asylums have larger percentages of such children to deal with, and that they not only teach, but also perform services that school children receive in their homes. Moreover, they have charge of many children under school age.

In visits or correspondence with three orphan asylums, a day nursery, a fresh-air mission, and an Indian school, the information invariably given was that the care of mentally abnormal children was not within the scope of these institutions' activities. Just as invariably, however, it was revealed that a number of such children find their way into these institutions and constitute a vexing problem. Owing to the inadequacy of institutional provision by the state for such cases, orphan asylums are often forced to care for them indefinitely.

As it is not their policy to do such work, special classes, systematic mental examinations, and psychiatric work are not attempted by these institutions. One exception was noted in the county—namely, a group of Catholic institutions in Lackawanna, which has a special class and in which a certain amount of psychiatric work is done. (It should be noted that the Thomas Indian School is planning to introduce intelligence tests, and has the coöperation of the state board of charities in its plans.)

Following is a list of institutions for the care of orphaned, dependent, and delinquent children in Erie County:

In Buffalo.
- Buffalo Orphan Asylum.
- St. Vincent's Female Orphanage.
- Fitch Crèche.
- Fresh Air Mission.
- St. Agnes Training School for Girls.
- Asylum of Our Lady of Refuge.
- Charity Foundation of Protestant Episcopal Churches.
- College Crèche.
- Crippled Children's Home.
- Evangelical Lutheran St. John Orphans' Home.
- German Roman Catholic Orphan Asylum.
- Immaculate Heart of Mary Orphan Asylum.
- Jewish Mothers' Club Nursery and Temporary Home.
- Le Couteulx St. Mary's Institution for the Improved Treatment of Deaf Mutes.
- Mt. Carmel Guild Day Nursery.
- Protestant Home for Unprotected Children.
- Rosemary Smith Home.

Outside of Buffalo.
- Our Lady of Victory Infant Asylum, Lackawanna.
- Thomas Indian School, Iroquois.
- Josephine Goodyear Convalescent Home, Williamsville.
- Jewish Fresh Air Camp, Angola.
- Methodist Home for Children, Williamsville.
- St. Joseph's Boys' Orphan Asylum, Lackawanna.

As a special instance of some of the difficult problems occasionally confronting those in charge of orphan asylums, the following may be mentioned:

A boy of unknown parentage, judged to be about four years of age, was found on the doorstep of one of the institutions with a letter pinned to his clothes stating that he had had meningitis and as a result had become mentally defective. At the time the institution was visited, he had been there only a week or two. He bites other children, takes plates and other dishes from the table, digs his fingers into the food, will not use a fork or spoon, is very intractable, and on one occasion tried to throw a glassful of water at the attendant. He walks with an unsteady gait, falls frequently, does not talk, but makes a great deal of noise. The attendant in charge of him thinks that he understands what is said to him, but is disobedient. No one in the institution thinks that he is a suitable case for detention there, but they are experiencing difficulty in disposing of him.

Unusual opportunities for observation and study exist in such of these institutions as care for infants of various ages.

The subject of anomalous behavior in infants has not received the attention and study that it merits. Observations of individual infants here and there in private families, under conditions so varied as to interfere with judgment as to what may be inherent and what of external origin in the tendencies of the child, are not to be compared with similar observations that could be made in institutions where the infants are under more or less uniform or known conditions.

In the ward for infants under one year of age in one asylum visited, the Sister in charge reported that peculiarities of a striking and persistent kind are frequently observed in some infants, who thus are markedly distinguished from others. Some exhibit a habit of rolling the head on the pillow. Others have a habit of rolling the entire body in the crib, which seems to have a sedative effect on the child, who is quiet when permitted to do this and soon goes to sleep, the rolling sometimes continuing after the child falls asleep and then ceasing gradually. Still others have a tendency to cry far more than is usual for infants, such crying being apparently attributable neither to hunger nor to discomfort from any external cause.

5. *Delinquent children* are dealt with partly by the children's court of Buffalo, with which is connected a small detention home; partly by the Children's Aid and Society for the Prevention of Cruelty to Children, which conducts an institution known as the Children's Shelter; and for the rest by the justices of the peace of the various townships in the county for whom is available the coöperation of the chief probation officer of Erie County, whose office is in Buffalo.

The volume of work of these agencies is striking. During the calendar year 1920, which is the last period for which official data are available in a published report, 1,176 cases were disposed of by the children's court, of which 1,060 were cases of boys and 116 girls. Of this number 134 boys and 41 girls were committed to institutions such as the State Agricultural and Industrial School, Industry; St. Agnes' Training School for Girls, Buffalo; New York State Training School for Girls, Hudson; Society for the Protection of Destitute Roman Catholic Children, Lackawanna; Berkshire Industrial School, Canaan, and so forth. Three hundred and thirty-five cases were discharged, 258 reprimanded and discharged,

262 placed on probation, and the remaining 145 disposed of in various ways—placed in the care of the commissioner of charities and corrections, fined, directed to make restitution and reparation, placed in homes, warrant withdrawn, etc. Of all those brought into court 209, or about 18 per cent, received a psychometric examination.

All court cases are investigated by the chief probation officer or one of his three assistants. The court authorities, however, feel that this work falls short of what it should be, both qualitatively and quantitatively. *It should include psychometric work, field investigations by psychiatric social workers capable of taking anamneses, and examinations by psychiatrists. Mental examinations should not be limited, as they are now, to about a fifth of the cases going through the court, but should be applied to all.*

The detention home consists of an old frame residence which has been altered to adapt it to its present purpose. On the ground floor are small offices, a dining room which is also used as the court room, and a small dormitory for girls, with five beds. Upstairs there is a fifteen-bed dormitory for boys. All windows are barred. There is, in addition, a single strong room which is used mainly for isolating venereal cases, but sometimes also for the seclusion of refractory children. There is a rather poorly equipped room for the examining physician, and scarcely any provision for diversion or occupation.

The period of detention is, in most cases, brief. Many stay only overnight, and the average length of stay is five days. The maximum permitted by law is thirty days. Yet some children are kept beyond that period because of lack of room in the institutions to which they have been committed. Occasionally a child is held for two months or more, mainly in cases of girls who are held as material witnesses.

It could hardly be said that the building is suitable for the purpose for which it is used. Furthermore, the dormitories being locked and barred, it would seem that an undue fire hazard is incurred.

The premises are kept in immaculate condition. The personnel are humane and kindly. We have been informed that the children are generally contented there, and many of them, especially the girls, regret leaving and do so at times with tears.

Here, as elsewhere, the work of mental hygiene is hampered by lack of adequate facilities and trained personnel.

The Children's Aid and the Society for the Prevention of Cruelty to Children and Children's Shelter are now merged into one organization, housed in a modern building. About 600 children between the ages of two and twenty-one are admitted a year. The building has a capacity of from 80 to 85 and is well equipped. Children are brought to this Shelter either by agents of the Society for the Prevention of Cruelty to Children or by order of the courts, or are referred by other agencies.

This institution conducts a psychological clinic, which engages the full-time services of a well trained psychologist. Almost all the children receive a psychometric examination, as well as a sociological and physical investigation. The clinic has available also the volunteer services of an excellent psychiatrist, who is in private practice in the city. Between 4 and 5 per cent of all cases have heretofore been referred to him for psychiatric examination.

Further development of this work is contemplated. Plans now being discussed which will probably materialize in the near future will enable the superintendent to provide two wards for psychopathic children, where they may be kept under special observation.

The work of this organization might be helped if more attention were given to the psychiatric training of the social workers employed and if more cases were referred for psychiatric examination. A merging of the work of the children's court with the work of this institution would, if feasible, justify the employment of a psychiatrist on full time and would obviate the need of depending upon free services.

Outside of the city of Buffalo there are no special children's courts, delinquent children being brought, like other cases, before justices of the peace. There are also no places for detaining delinquent children pending investigation and trial, and no facilities or personnel for either physical or mental examinations. Several of the justices were interviewed and all of them have been communicated with. They report that very few children are brought before them. One of them stated: "Since entering upon this office, I have had but one case of delinquency in a child—namely, in a girl about sixteen years

of age who had previously been committed to the House of the Good Shepherd and later was recommitted to the same institution, from which she ran away after breaking down doors, destroying furniture, and so forth. She was recaptured, and her mother took charge of her again. Just where she is now, I am unable to say. There is no doubt in my mind that this unfortunate girl is mentally deficient."

Another, who is both a justice of the peace and a school trustee, stated: "I know of no mental deficiency among the children in this neighborhood at this time. About the only cases that come before me are cases of truancy. Then the parents get it good and hard from me, for we make it as pleasant for the children in school as we can to make them want to come instead of playing hookey."

Still another justice of the peace related the case of a boy who had been brought before him four years previously. This boy had been brought up in bad surroundings. His mother had almost no control over him and he had a stepfather who often whipped him for trifling things, but paid no attention to serious wrongdoings. The boy had vicious tendencies. Once he took a kitten and cut out its eyes to see what it would do and then let it go. He stole knives, pencils, and other articles at school. Once he stole a new copper boiler which his mother had purchased, broke it up, and tried to sell it to the junk dealer. On other occasions he stole a cap and some small change out of a cash register in a store. He was committed to Industry, New York, for a year, but because of bad behavior there was kept a little longer. A couple of years later he took a girl out in a boat on the lake and they were both drowned.

Most of the justices of the peace do not know that the various facilities in Buffalo for the examination of children would be available to them upon application, but those with whom this point was discussed stated that the town would probably object to the expense that would be involved in transportation.

The county probation officer's headquarters are in Buffalo. He is supposed to have charge of children on probation in all parts of the county outside of the city of Buffalo, those in the city being in charge of a special department which the city maintains for that purpose. Owing to the difficulty of trans-

portation and shortage of personnel, the county probation officer has had but little contact with the justices of the peace in the various townships, at least so far as delinquent children are concerned. During the past fiscal year, probably not over fifteen or eighteen juvenile delinquents have been cared for by the county probation officer. The number of cases of children brought into the courts, however, must have been greater.

There is some prospect of an improvement in this situation through an increase of personnel in the department and the availability of an automobile for trips anywhere in the county.

The county probation officer has various ways of having a child examined mentally, such as taking it to one of the outpatient clinics conducted by the Buffalo State Hospital or to the Children's Aid diagnostician. But usually he refers cases to a private physician who is engaged in psychiatric work and has the examination made on a fee basis. Not all children receive a psychiatric examination. This is one of the many instances which show that a better coördination and use of the available facilities for making mental examinations of children would result in more complete and more thorough work.

6. The Erie County *board of child welfare* reports that during the calendar year 1919, 334 families were given aid by their organization and during 1920, 273 families. All children received a physical examination either at one of the health centers in the city or in the city tuberculosis clinic or at the hands of private physicians. During the year 1920, 1,167 children were examined. Only a small number received a mental examination—namely, either those whom the physician making the physical examination especially referred for such an examination or those who were reported as doing very poorly at school.

Owing to the difficulty and expense of transportation, the children in the rural parts of the county are seldom brought to the city for examination and hardly any of them are mentally examined. *If various parts of the county were visited by an itinerant mental clinic, all dependent children in the rural districts could receive a mental examination. The mothers of these children also could receive a mental examination, and thus the law would be more strictly complied with.*

7. The *out-patient mental clinics* conducted by the state hospitals in Erie County consist of three conducted by the Buffalo State Hospital and one conducted by the Gowanda State Hospital, all in Buffalo.

Although both the Buffalo and the Gowanda State Hospitals have announced their readiness to examine either children or adults at any time that they may be brought to the hospital, patients are very seldom thus referred to them. There is a strong and general objection to going to an institution for mental disease or to sending a child there for an examination.

Of the four out-patient clinics, two are as a rule used only for adults, while the remaining two—one conducted at the Jewish Community House every Wednesday morning from 10 to 12, and the other at the Children's Hospital every Thursday afternoon from 2 to 4—are mainly for children. During the year ending June 30, 1921, 148 children under sixteen years of age were examined in this clinic, but scarcely any of them came from the rural parts of the county, owing chiefly to the difficulty and expense of transportation. The great majority of these patients were diagnosed as mentally deficient or mentally retarded, but there were also cases of psychopathic personality, epilepsy, and psychoneurosis, and 23 were designated as normal. Full advantage of these clinics has not always been secured, owing, apparently, to the lack of careful planning in advance as to the type of diagnostic service that might best help the other organizations; but this is merely a matter of adjustment, as the personnel and equipment are of the highest quality.

It is obvious that these clinics are not serving the rural areas of the county, and a mere increase in numbers, even if in new locations, would still leave most of the outlying sections without service.

In order to make psychiatric service available for the schools, justices of the peace, overseers of the poor, health officers, and other organizations and officials throughout the county, it would be necessary to organize an itinerant mental clinic. Such a clinic could visit each of the twenty-five townships in the county outside of Buffalo twice each year, and should be arranged through the county health council in

coöperation with any consultation or supervisory medical work for the schools. These visits, if announced in advance, would enable the rural authorities to have children and others selected for mental examination, so that periodically the psychiatric problems in every community would be placed in the hands of those best able to deal with them efficiently.

As far as the state hospitals are concerned, such an itinerant clinic would not involve the employment of more personnel or the expenditure of a greater amount of time than would be necessitated by the establishment of but one additional fixed out-patient clinic with a single weekly session. The only added expense would be that of automobile transportation once a week.

If the two state hospitals in the county would divide between them this work, so that the Buffalo State Hospital would send out its itinerant clinic to the townships in the northern half, and the Gowanda State Hospital to those in the southern half of the county, then for each of these institutions the establishment of such an itinerant clinic would involve but half the labor and time that would be required for the establishment of one additional clinic in a fixed locality.

If a coöperative plan for itinerant consultations involving more than one medical service should be worked out in coöperation with the proposed county health unit, this would mean decided economy in personnel and transportation.

Outside of the work in their out-patient clinics, the state hospitals have seldom opportunities of rendering psychiatric service in cases of children. This is due to the striking rarity of psychoses in children under sixteen years of age. At the present time there is not one patient under sixteen years of age from Erie County in the Gowanda State Hospital, and but one in the Buffalo State Hospital. During the year ending June 30, 1921, but seven patients from Erie County under sixteen were admitted to the two hospitals, three of whom had manic-depressive psychoses and four dementia praecox.

8. *The department of health* of the city of Buffalo has a special bureau for child hygiene which includes a division for mental hygiene. This division employs a physician on part time who has specialized in psychometric work and who examines cases referred by the schools, the children's court,

orphan asylums, and other city and county agencies. This division works in coöperation with the division for special classes in the department of education.

9. *The department of hospitals and dispensaries* of the city of Buffalo has suggested a far-reaching plan for psychiatric service to be rendered to children in the city schools, such service to be made available for children elsewhere in the county as well by bringing them to the city where the facilities are located.

Considerable progress has been made in the establishment of facilities for such work. In connection with the Buffalo City Hospital, a new psychopathic ward has just been completed and is about to be furnished and opened for the admission of patients. It has a capacity of forty beds, is equipped with hydrotherapeutic, electrotherapeutic, and diagnostic appliances, and has provision for the classification of cases according to sex, age, and mental condition.

The new psychopathic ward is so located in relation to other departments of the hospital that in case of need it would be possible to convert other wards into additional mental wards, thus not only increasing the capacity of the neuropsychiatric service, but also further multiplying facilities for classification.

The visiting physician in charge of the psychopathic ward also holds the chair of psychiatry in the medical school of the University of Buffalo.

10. *The county superintendent of the poor* has his office in Buffalo, and many cases of dependent children are referred to him by overseers of the poor and others throughout the county.

At the time of this study, there were reported to be approximately 2,358 children under the charge of the superintendent of the poor, of whom 1,298 were in orphan asylums and other institutions, and 1,060 were in boarding homes, in free private homes, or with their mothers, to whom maintenance was being paid by the county.

The principal causes of dependency in these children's cases were the illness or death of one or both parents, desertion by father, father in prison, mother feebleminded.

The superintendent of the poor deals with mental disorders

in childhood only in those marked cases in which the necessity arises for commitment to an institution for epileptic persons or for the feebleminded. Although the present incumbent of this office is very conservative in the matter of committing children to such institutions—feeling that it is a step justified only as a last resort and that even a definitely feebleminded child should first be tried in a private home or on a farm before commitment is decided on—yet he finds the state's facilities for the care of children who must be committed to such institutions very inadequate.

At present he states that the county is compelled to maintain fifteen children in the Brunswick Home in Amityville, Long Island, a private institution to which the county pays a certain amount per week for the maintenance of these children.

Not only are the facilities that the state provides for feebleminded, epileptic, and otherwise mentally abnormal children inadequate, but such facilities as are available are in institutions located for the most part hundreds of miles distant from Erie County. Owing to this circumstance, the relatives of children who should be committed are often unwilling to consent to such commitment, as the children would have to be taken so far from their homes that visiting would be rendered difficult or impossible.

From the superintendent of the poor and from other sources we have learned that *there is a great need for an institution for mentally defective persons in the western part of the state.* Owing to the fact that the state makes such inadequate provision, Erie County has developed a plan to build at Alden, where it owns nine hundred acres of land, an institution which would include an almshouse, a penitentiary, and a separate department for mentally defective persons.

11. Erie County, especially Buffalo, is unusually well supplied with neuropsychiatrists. Outside of those who are on the medical staffs of the two state hospitals, there are in private practice at least ten psychiatrists, or neurologists interested in psychiatry, seven of whom have had state-hospital experience. They are available for work on a fee basis; but most, if not all, are also ready to offer their services gratis, so far as they can spare the time, to public institutions. Some

are on the medical staff of the Buffalo City Hospital and others are employed on part time on a small-salary basis by the department of health for psychiatric work.

Agencies Existing Outside the County.

The following institutions in New York State outside of Erie County which are rendering or may render service to children of the county should be especially mentioned, as some of them care particularly for mentally defective persons, and there is as a rule a high percentage of atypical children in institutions of the types represented by the others.

1. *Syracuse State School,* at Syracuse, has 13 children from Erie County. Three others have had applications filed and are on the waiting list.

2. *Rome State School,* at Rome, has 57 children from Erie County. While none are officially on the waiting list, it is reported that many would be if vacancies were known to exist.

3. *Letchworth Village,* at Thiells, has 17 children from Erie County. Two others have had applications filed and are on the waiting list.

4. *Craig Colony,* at Sonyea, for epileptic patients, has 11 children from Erie County; none on the waiting list.

5. *State School for the Blind,* at Batavia, has some children from Erie County; the exact number was not ascertained. The superintendent writes that all newly admitted pupils are given psychometric tests, and that once every year or two a psychologist visits the school and further examines doubtful cases for possible mental deficiency. Children who are found to be of such low mentality as to be unable to profit by the advantages of the school are sent home or transferred to institutions for the feebleminded. Occasionally a case of epilepsy is observed.

6. *The Jewish Orphan Home,* at Rochester, has 19 children from Erie County. Only in a small proportion of cases have psychometric tests been made. The annual report states that occasionally delinquent or feebleminded children are admitted there, although it is contrary to the declared policy of the institution to receive them. When a child is discovered to have a marked mental abnormality, they try to dispose of it either by discharge or by transfer to an institution for the feebleminded.

Recommendations

In order to formulate recommendations for the more purposeful utilization of existing facilities and resources of the county for the work of mental hygiene among children and for the creation of new facilities required to round out the existing organizations, it is necessary, first of all, to determine upon a general plan of mental-hygiene activities as the goal to be attained.

1. *Work in the Schools.* It would seem highly desirable to introduce in the schools the systematic practice of group tests of intelligence. On the basis of these tests and also on the basis of retardation in school work, anomalies of behavior, and evidences of nervous or mental disease, children may be selected for individual examination.

Perhaps the next step would be to provide for individual psychometric tests in all cases thus selected.

The third step would be to investigate the home conditions in each case and to secure full anamneses with the aid of psychiatric social workers. These investigations and anamneses, together with the general medical examinations that school children receive, should form a basis for explaining such phenomena as retardation, truancy, unruliness, and so forth.

The final step would be an examination of the data already collected and of each atypical child individually by a trained psychiatrist, which should lead to a diagnosis and recommendations for the treatment and disposition of the case.

The school system should further develop its facilities, such as special classes, trained personnel, and so forth, for carrying out the recommendations resulting from investigations of children as outlined above.

2. *Work With Children Not in the Schools.* For children who come to attention by reason of nervous or mental disorders developing before or after school age and for those who come to attention by reason of dependency or delinquency, provision should be made for investigation along lines similar to those outlined above for school children.

The plan here suggested would meet to a large extent the social-hygiene needs of children, inasmuch as psychiatric problems are often found underlying social diseases among them. The timely discovery and attack upon such problems

would in many cases constitute a measure of social hygiene—that is to say, prevent venereal disease. For the rest, social hygiene must be considered a part of any well-rounded plan of general health work.

3. *Need of Trained Personnel.* One of the first needs brought to light by this study is that of trained personnel for the various phases of work in mental hygiene. At the present time, owing to the imperfect organization of existing facilities, it is not only true that the energies of the valuable personnel are inadequate for the work that has to be done, but also that these energies are employed in an uneconomical way. It should not be necessary for a psychiatrist of fifteen or twenty years' experience to do psychometric work or take anamneses, inasmuch as many teachers and others can readily be trained to do it.

It is recommended that teachers who are interested in such work be trained to perform group tests. Such work could be safely entrusted to them, as its object would never be the final and definite classification of children, but only a preliminary classification intended as a basis for further investigation. Other teachers, possessing better qualifications of education and experience, should receive more advanced courses of training to fit them for the more responsible work of individual psychometric testing. A third group either of teachers, school nurses, or social workers, should be given courses in psychiatric social work, including practice work in field investigations and obtaining psychiatric anamneses. Finally, a fourth group of teachers should be trained for various phases of work with atypical children in special classes.

In the course of the survey, a canvass was made of educational institutions in which such training might be provided. In the University of Buffalo, Departments both of Medicine and of Arts and Sciences, extension courses and summer courses are already being given in applied psychology, abnormal psychology, and psychiatry. Conferences with heads of departments have led to the conclusion that it would be entirely practicable to outline and provide courses specially devised for training personnel for the various kinds of mental-hygiene work mentioned above.

In the State Normal School in Buffalo there is an excellent

department of psychology in which also far-reaching attempts have been made to develop summer courses in applied psychology. With the increase of the regular normal-school course from two to three years, further development of that work for all student teachers has been planned.

Perhaps the most significant steps in this direction have been taken by the State Normal School in Geneseo in coöperation with the Craig Colony. This school conducts practical courses at the Craig Colony for the purpose of supplying special training to seniors who are interested in work with atypical children. Eight critic teachers have for nearly two years been maintained on full time at the Craig Colony, being paid from the budget from the Geneseo State Normal School a usual salary, minus a deduction of $240 a year in lieu of which they receive room, board, and laundry at the colony.

These teachers have organized classes of from eight to twenty-five pupils selected from among the patients in the colony. The teaching consists in academic work, weaving on looms, lace making, tatting, crocheting, plain sewing, rug making, carpentry, chair caning, toy making out of rags and out of wood, kindergarten training, physical culture, and singing. Groups of about five or six student teachers are assigned to work at the colony for a period of one week for each group. They derive from such an assignment an opportunity to observe methods of instruction; a certain understanding of various mental and physical handicaps which should help them to recognize such handicaps and make intelligent allowance for them upon encountering them in the course of teaching; also a certain amount of training in the work itself that is being taught to the children, such as various stitches, how to use a loom, and so forth.

These courses are optional, but of about 200 senior students no fewer than 120 have signed their names to applications for them. They constitute, of course, only an introduction to the needed training, but the normal-school authorities plan to increase their scope and their variety so as to fit teachers for the various phases of mental-hygiene work among school children, such as those enumerated above.

This special development of the Geneseo State Normal School would by no means eliminate the need for extension

courses in Buffalo University, Buffalo State Normal School, and possibly in Canisius College. For those teachers whose work is in Buffalo it would be advantageous if special courses were offered in the local educational institutions, for only thus would they be enabled to utilize any spare time they may have during afternoons, evenings, and Saturdays for getting such training.

4. *Standards for Psychometric Work.* Perhaps this is the proper place to refer to the uncontrolled and often incompetent psychometric work that is done in many places. It would seem to be the proper function of the American Psychological Association to decide upon standards of requirements for the various kinds of psychometric work that has to be done. Those engaged in this work should be able to show that they have conformed to such standards and should thereupon be officially certified by a proper committee of the association, the certification specifying whether it be for administering group tests, or for individual tests in the capacity of assistant, or for independent work as professional psychologist. Courses offered by the universities, colleges, and normal schools should be planned with a view to meeting such requirements.

5. *Increased Institutional Accommodations Needed.* Very often the recommendations that result from a psychiatric study of a child cannot be carried out on account of lack of necessary facilities. Some of the special needs have already been discussed. The most urgent are a new institution for the feebleminded in the western part of the state of New York, perhaps in Erie County, and the establishment of more special classes for atypical children in the public schools. It should be noted in this connection that, as far as parochial schools are concerned, the Lockwood Law is not mandatory, but optional.

6. *Psychiatric Service for Rural Areas.* The greatest obstacles in the way of organizing special classes are encountered in rural parts of the county. The chief improvements will probably come through the combination of school districts referred to on page 778; but even then rural schools will still be at a disadvantage in comparison with urban

schools, for the reason that one school, even if it be a large one, cannot organize special bureaus like those carried on by the department of education of a large city. While a larger rural school can develop personnel for group testing, individual testing, psychiatric social work, and teaching of special classes, it cannot so readily secure the services of trained psychiatrists whenever needed.

In order to help rural areas, and especially rural schools, meet the need for trained psychiatric service, organization of an *itinerant mental clinic* is recommended. This has already been referred to and its general plan described. Information secured from neuropsychiatrists practicing in and around Buffalo indicates that some, if not all, would be willing to accept positions on the staff of such an itinerant clinic and thus relieve the state hospitals to some extent of the burden of carrying it on. However, such a clinic should be under the control of the state hospitals, just as the fixed clinics are, in order to insure proper supervision, standards, records, and reports. It should, of course, conform to the plans and procedure for the medical examination of school children, especially in so far as they relate to itinerant consultation or clinic work.

7. *Organization for Continuing Work.* The next recommendation deals with the problem of so organizing and controlling mental-hygiene work in the county, especially among children, as to secure for it the highest measure of efficiency with the least expenditure of energy and resources.

There should be some agency for coördinating the mental-hygiene work of the schools of the city and of the rural parts of the county, orphan asylums, children's courts and justices' courts, the Children's Aid Society, the board of child welfare, the two state hospitals, the department of health of the city of Buffalo, the department of hospitals and dispensaries, the office of the county superintendent of the poor, and neuropsychiatrists in private practice.

In order to bring this about, it would perhaps be best to organize an Erie County committee for mental hygiene as a committee of the Erie County health council. To this committee might belong public-spirited citizens and, *ex officio*,

officials who are concerned with the education, management, and control of children, including not only heads of large departments, but also representatives of such groups as the school teachers, nurses, social workers, physicians, psychologists, probation officers, justices of the peace, and overseers of the poor.

This committee should have a carefully selected executive board and should have as one of its objectives the organization, through paid workers, of a complete program of mental-hygiene work in each part of the county, as part of the general public-health program.

The objects of this committee should be carefully formulated, and among its functions should be that of furnishing scholarships to enable teachers, nurses, and others to take special courses of training provided by universities and colleges in extension teaching and summer sessions. It also should be one of its functions to hold from time to time meetings, not only for its own members, but open to the public, at which important subjects in mental hygiene should be discussed by competent authorities in a way to be of educational value to those in attendance.

8. *Research.* In general, the most obvious need for the development of mental hygiene among children—one that did not require a survey to bring it to light—is that of organizing research for increasing our knowledge of the mental disorders of childhood.

Although psychiatry has made great strides in the last twenty-five or thirty years, this part of it has not kept pace with its general progress.

Owing to the fact that any mental disorder occurring in childhood, no matter what its nature, is apt to act as an obstacle to development in intelligence, the tendency has become prevalent to diagnose almost all cases as mental deficiency. This tendency has been strengthened by the undue reliance that it has become customary to place upon a showing made in psychometric tests.

Should it prove possible to organize the work of mental hygiene among children along the lines indicated in the above recommendations, unprecedented opportunities would be created for research in this branch of psychiatry. It need

hardly be emphasized that, with the possible exception of eugenic measures, there is no more important field of psychiatric prophylaxis than that of work among children. It is, therefore, to be hoped that either in Erie County or elsewhere, in the near future, some such organization as is here suggested may be developed and thus the stage set for research and further progress.

THE SOCIAL-SERVICE DEPARTMENT AND ITS RELATION TO AN EXTENSIVE PAROLE SYSTEM.*

HARRY A. STECKEL, M.D.

Senior Assistant Physician, Kings Park State Hospital, Kings Park, New York

FOR more than two years the Kings Park State Hospital has been doing intensive extramural work in the way of parole and after-care. As a result of this work, we have not only gradually increased our number of patients on parole, but we feel that we have during this period collected sufficient data to prove that many patients whom it was formerly thought necessary to detain in a hospital for mental disease may be safely cared for in the community, and even become self-supporting and useful members of society.

The idea of a parole system and of a social-service department is not a new one nor did it originate with us. In fact, as long ago as 1912, Homer Folks, Secretary of the State Charities Aid Association, advocated the establishment of the parole-system and after-care plan that we are now carrying on, with, of course, such amplifications as have been deemed advisable and necessary. We do believe, however, that our work in this line has been more intensive than similar work anywhere else in the state, and that our results will tend to meet many of the objections that have at times been raised against parole and after-care.

Advocates of an extensive parole system often point to its financial benefits, while opponents reply that the added expense of a large social-service department counterbalances to a great degree this financial advantage. In order to show in actual dollars and cents what has been saved the state at this hospital alone during the two years 1918-1919 and 1920-1921, we have collected the following data:

During the fiscal year ending June 30, 1919, we expended for salaries, wages, maintenance, and traveling expenses of

* Read at a special meeting of the Kings Park Medical Society, Kings Park, New York, May 23, 1922.

the personnel of the social-service department and for the transportation of patients, $4,496.38. During this year the daily average number of paitents on parole was 304.

In the year ending June 30, 1921, owing to a large increase in the personnel of the department and the resulting growth of its activities, $14,410.92 was expended for salaries, maintenance, and so forth. However, as a result of the increased activities rendered possible by the augmented personnel, the daily average number of patients on parole during the year was increased to 669, a gain of 365 over the year ending June 30, 1919. The annual cost of maintenance in the hospital being $379.53 per patient, the gross saving amounted to $138,528.45, or a net saving of $128,613.91.

This does not take account of the money earned by patients who were employed during their parole period. We were able to get definite information regarding 280 patients paroled from July 1, 1920, to June 30, 1921. These 280 earned during their parole period $134,344.00.

As to savings, we were able to secure accurate information only regarding patients paroled to general hospitals, and find that 89 patients so paroled have saved $6,282.00.[1]

It seems to us that this is an admirable showing, amply justifying the maintenance of a large social-service department and the continuance of an extensive and intensive parole policy.

Furthermore, every patient on parole makes room for a new patient. If it had been necessary to erect new buildings to house a number of patients equal to the number on parole, there would have been a far heavier expenditure than that actually made.

This is only one of the many advantages of an extensive parole system, but perhaps the one that appeals most strongly to a certain type of "business man", who thinks largely in terms of the dollar.

In addition to this concrete benefit, there are, of course, many others. The paroling of suitable patients helps to relieve the overcrowding that exists in the majority of our institutions. Perhaps even more important, recovery is often hastened when a patient can return to his home and familiar

[1] Corrected to January 1, 1921.

surroundings during the period of convalescence, at the same time remaining under the supervision of the hospital through the agency of an efficient social-service department. Without such careful oversight of paroled patients while they are making environmental readjustments pending complete recovery, it would not be wise or possible to parole large numbers, or to parole them so early after the disappearance of acute psychotic manifestations. This, of course, applies particularly to the recoverable cases.

What about the chronic patients, those whom we do not expect to recover entirely?

We can cite case after case of so-called chronic patients who, in spite of their oddities of conduct or hallucinations, have been able, with assistance, to do well outside the hospital—such patients, for example, as the following:

Case 1. B. E. Ident. No. 82335, female. Admitted April 22, 1915. Age 50. Diagnosis: dementia praecox, paranoid form. Psychosis began six months before admission; heard husband's voice accusing her and telling her that she was going to have trouble. Thought people watched her; thought electricity was being put on her. These trends continued throughout her hospital residence, and she never developed insight. She was always quiet and tractable, however, and on July 13, 1920, a position was secured for her with a family in Smithtown Branch. While there, she did excellent work, but early in April 1921 she became acutely disturbed in reaction to tactile hallucinations, and although she was not dangerous in any way, it was found necessary to return her to the hospital. She soon quieted down, however, and was employed about the ward. On June 28, 1921, she was paroled to an employer in Kings Park, where she has been getting on very well ever since, doing housework and taking care of a small child. She has saved approximately $300.00 during these two years. At the present time she has again become rather restless and insists on establishing a home of her own in Brooklyn, but apparently is not reacting to any great extent to hallucinations. The prognosis for recovery in this case is very poor, but we see no reason why she should not be able to be paroled from time to time, and spend the majority of her time outside.

Case 2. H. G. Ident. No. 14990, male. Admitted August 10, 1907. Diagnosis: dementia praecox, paranoid form. Patient came voluntarily to the hospital because he was annoyed by auditory hallucinations, thought people knew his thoughts and ridiculed him. These voices advised him to kill himself and at times threatened to kill him. On admission, he showed nothing other than this, except perhaps a dull, shallow emotional tone. He remained essentially unchanged for more than ten years, still complaining of auditory hallucinations, which annoyed him more or less from time to time, but which did not interfere

to any great extent with his conduct. On October 23, 1920, he was paroled to the custody of St. John's Hospital, Brooklyn, where a position as hospital orderly was found for him. He has been getting along exceedingly well there and his services are not only satisfactory, but he is very popular, and has saved more than $200.00.

Case 3. M. W. Ident. No. 104514, female. Admitted February 14, 1918. Diagnosis: alcoholic psychosis, Korsakoff. She was committed because she went to the homes of neighbors for meals and insulted and inflicted bodily injury upon a neighbor and her children. Acted irrationally. Threatened to kill the neightbor's child. On admission, she showed no restlessness, but exhibited some defect in personality, appearing rather simple and shallow. She had no insight, had vague persecutory ideas, and showed loss of memory for remote events, upon which fact probably the diagnosis was based. She continued to deteriorate, was unusually quiet and seclusive, seldom speaking to other patients. Memory and orientation finally became very much disturbed, but other than this the patient showed nothing unusual and was able to do good work about the wards. On June 30, 1920, she was paroled to the custody of St. Catherine's Hospital, where she has been employed ever since and is doing satisfactory work, although she requires considerable supervision, owing to the fact that her memory is so poor.

To say that a patient belongs in the chronic group means nothing more than that he is suffering from a prolonged mental disease, such as dementia praecox, senile dementia, general paresis, arteriosclerosis, and the like. Complete recovery of such patients is not to be looked for, but partial social recovery is quite possible, everything depending upon a proper adjustment of environmental conditions. Control over the patient's mental state can be exerted within very narrow limits, but control of the conditions of his environment can be developed indefinitely. It is, then, upon this factor of environmental control that we must depend if we are to increase the number of these patients on parole.

True, many of these chronic patients, especially the more deteriorated, earn only very meager wages in addition to their maintenance, but they enjoy the advantage of living outside an institution for mental disease, have as a rule more comfortable quarters—at least less crowded—and show a distinct elevation of morale such as comes only with a sense of independence, never enjoyed by those within an institution.

We have found that it is very difficult to arrange for the parole to relatives of chronic patients, particularly those whose hospital residence has been prolonged, chiefly because

the family is apt to have so modified their domestic life that it becomes impractical to take the patient back into the home. They have possibly been repeatedly told that the patient would never recover, would always require hospital care, and they have adjusted their lives accordingly. We now believe that no case should be given so hopeless a prognosis, but that the relatives should rather be encouraged in the hope that, although the patient may never completely recover, there is every possibility that he or she will improve sufficiently to permit of extramural care. By thus holding the interest of the patient's relatives, we are later on better able to arrange for a trial on parole within the home; and with a liberal parole policy, we believe that the average length of hospital residence may be appreciably reduced.

A glance at the following table may be enlightening:

Table 1. Length of Hospital Residence of Patients Paroled During the Years Ending June 30, 1920 and 1921

Hospital Residence	1920	1921
Less than 1 month	64	65
1 to 2 months	87	107
2 to 3 months	72	85
3 to 4 months	41	62
4 to 5 months	38	56
5 to 6 months	26	51
6 to 7 months	46	21
7 to 8 months	38	28
8 to 9 months	30	22
9 to 10 months	26	19
10 to 11 months	20	18
11 to 12 months	24	20
1 to 2 years	146	158
2 to 3 years	88	81
3 to 4 years	70	78
4 to 5 years	41	60
5 to 6 years	30	45
6 to 7 years	15	28
7 to 8 years	18	15
8 to 9 years	13	22
9 to 10 years	10	21
10 to 15 years	26	55
15 to 20 years	13	25
20 to 25 years	3	23
25 to 30 years	4	2
More than 30 years	3	5
Total paroled patients	992	1,172

It will be noticed that during the year July 1, 1920, to June 30, 1921, the tendency has been to parole more patients within the first six months after admission than during the previous year. Also, the number of so-called chronic patients paroled shows a marked increase over the previous year, this being especially noticeable in those patients whose hospital residence has been more than four years. This, we think, shows the effect of intensive effort to parole larger numbers of patients and indicates an increasingly liberal policy toward parole possibilities.

To return to the consideration of the benefits of intensive parole work, do we notice any beneficial effect upon the patients who remain in the hospital?

Dr. Rosanoff[1], in a recent paper on the parole system and its relation to occupational therapy, said: "Perhaps the most significant result has been the development of workers out of previously idle patients and the striking general improvement produced thereby in their mental condition. Some improved sufficiently to be in their turn paroled for extramural employment." We believe, therefore, that a liberal parole policy is of actual value as a therapeutic agent and, as Dr. Rosanoff pointed out, "acts as a powerful stimulus, inducing many to work who under ordinary conditions stubbornly remain idle".

It would be natural to expect that if we depleted the hospital of all its trained workers, the work of the hospital would suffer. This, however, has not occurred to any noticeable degree. Perhaps a little extra work has fallen to the attendants in that they were required to train previously idle patients and consequently maintain a closer supervision of the work, but the condition of the wards and grounds has, we think, actually improved, in spite of the fact that the majority of our best workers among the patients have been paroled.

An important question to be considered in connection with an extension of the parole system concerns the types of patients that may be safely paroled. To answer this one must ask another—namely, what is meant by "safely"? I

1 *The Parole System and Its Relation to Occupational Therapy*, by A. J. Rosanoff and T. S. Cusack. *The American Journal of Insanity*, October 1920, Vol. 77, pp. 149-63.

think I may say that, briefly outlined, our policy at this hospital has been that any patient who is neither suicidal nor homicidal, whose behavior would not in any way prove annoying to his neighbors or whose actions would not tend to bring him into undue prominence, should be considered a parole possibility. Needless to say, no patient who is noisy or destructive to property should be paroled, as no amount of environmental adjustment could effectually prevent such patients from annoying those about them.

Aside from the suicidal and homicidal patients, whose parole, of course, is not permissible, and the noisy or destructive patient, there are two other types of patient whose tendencies, although not strictly speaking dangerous, are apt to get them into difficulty or to bring them unduly to public attention.

The first is the type commonly known as chronic elopers. Our experience has been that although a certain proportion of patients who escape from the hospital do so because they wish to reach their homes, a great majority of them are simply chronic wanderers and would fail to remain for any length of time in any one environment, no matter how suitable or how comfortable it might be for them. It is exceedingly difficult to keep in touch with these patients and they are always being picked up by the authorities because of their oddities of conduct or their inability to support themselves. The following is a typical case:

Case 4. H. A. Ident. No. 97729, male. Age 39. Admitted March 31, 1921, by transfer from Brooklyn State Hospital, where he was admitted April 17, 1917. Psychosis was characterized by auditory hallucinations, apprehensiveness, and delusions of persecution. Improved shortly after admission and soon became quite efficient in caring for the sick. August 13, 1918, he was paroled and employed as a ward attendant. This continued for only five days, when he began reacting to auditory hallucinations and was again returned to the ward on August 28. April 1, 1919, he was again paroled and employed. July 7, 1919, he left the hospital without notice and was returned July 12, complaining of auditory hallucinations. March 8, 1920, he was again paroled and employed, but on March 25 he left without notice, going to a rooming house. He was returned March 27, saying that everybody was against him. September 4, 1920, he escaped from the grounds, going to Baltimore, and was returned from there September 29. March 31, 1921, he was admitted by transfer to Kings Park State Hospital. He was an excellent ward worker, showed no trends of any kind after a month or

two, and on September 6, 1921, was paroled to the custody of St. Mary's Hospital. On September 19, 1921, he was returned from parole, having left St. Mary's Hospital seeking another position. Being unsuccessful in this, he voluntarily gave himself up to the police, who sent him to Brooklyn State Hospital. Since this time the patient has escaped from the hospital on one other occasion, but was picked up the same day several stations distant from the hospital and returned. This patient apparently is unable to remain for any length of time in any one place, and is a wandering type for whom parole is contraindicated.

The other type of patient that is apt to attract too great public attention, and that therefore may be said to be in the class of patients not to be paroled with safety, are those who, owing to some persecutory trend, are in the habit of writing letters to prominent people, such as police commissioners, mayors of cities, governors of states, and even the President of the United States. We believe that, although this tendency does not constitute an actual danger, it is annoying to those who receive the letters and is certainly a contraindication to extramural care, for no matter how close supervision may be, the patient invariably gets letters into the mails. This not infrequently happens even while the patient is in the hospital, so that we feel safe in saying that it would be utterly impossible to prevent it outside the hospital.

With the exception of the above mentioned types, we believe that any patient may be safely paroled, given the proper supervision and the proper environmental adjustment.

Table 2 shows the psychoses of patients paroled during the two-year period 1919-1921.

Table 2. Diagnosis of Patients Paroled During the Years Ending June 30, 1920 and 1921

Psychosis	1920	1921
Dementia praecox:		
paranoid form	333	385
simple form	69	74
hebephrenic form	54	71
catatonic form	30	29
Manic-depressive psychosis:		
manic type	96	100
depressed type	82	97
mixed type	52	51
Constitutional psychopathic personality	42	67
Mental deficiency	38	55

Psychosis	1920	1921
Psychoneurosis	29	18
Alcoholic psychosis	47	45
General paresis	24	22
Epileptic psychosis	18	36
Involution melancholia	20	22
Paranoid condition	21	40
Other psychoses	37	60
Total	992	1,172

So far as we know, no special significance can be attached to these figures, and it is quite possible that there might even be some dispute as to the accuracy of the diagnoses made. What we wish particularly to show is that practically all psychoses appear on the table and that the matter of parole should not depend upon the diagnosis made for classification purposes. In discussing the types of patients possible for parole, we have deliberately avoided referring to diagnosis because we consider it irrelevant, the relationship of the symptoms to the environment being the essential factor.

We have, without mishap, paroled patients who are still hallucinated. Hallucinations may be harmless so long as they are not of a persecutory variety. Even where of a persecutory nature, if they are of long standing and if the patient's emotional reactions have become blunted by deterioration, the hallucinations seldom interfere with his ability to get along well outside.

One case of this nature will bear citing:

Case 5. H. L. S. Ident. No. 16628, male. Admitted April 5, 1905. Age 35. Single. Commitment stated that onset was gradual. Patient seemed depressed; spoke freely about his delusions and hallucinations; showed no insight into his condition. Patient said *that for the past few weeks men had been following him about in the streets, and when he went home at night, they would gain access to the house to spy upon him;* he could overhear conversations in which they plotted against him, threatening to shoot him or to get rid of him in other ways. While he was in jail, they attempted to poison him. A diagnosis of dementia praecox, paranoid form, was made. The patient continued throughout his hospital residence to react to auditory hallucinations, upon which were based delusions of persecution. He was, however, quiet and tractable, working about the grounds, and for several months prior to his parole, he enjoyed a ground parole. October 23, 1920, a position was found for him in the Cumberland Street Hospital, where he did porter work for several months. This gave him an opportunity to get in touch with his former friends and members of the Printers' Union

and he is now employed as a night linotype operator by one of the well known New York City morning papers, earning from $65.00 to $70.00 per week. His general attitude remains unchanged, he being seclusive, at times almost odd in his behavior; but he is well able to get along outside the hospital.

Persecutory trends often are directed against friends or relatives. It has been our experience that patients with such trends are well able to get along in an environment removed from relatives or friends. The patient seldom makes any attempt to locate such imagined persecutors, especially if there has been a long hospital residence with some slight dulling of the emotional reactions.

Marked deterioration, oddities of conduct, hallucinations, even mild persecutory trends are, therefore, not contraindications to parole. We believe that the safety of parole depends not so much upon the symptoms of the individual patient as upon the environment into which he is paroled and in which he is to be cared for, each case having some special features that must be especially dealt with in adjusting the environment.

It is the function and the purpose of the social-service department to make these adjustments—this being accomplished at the pre-parole visits—to see that special provisions with reference to the after-care of the patients are carried out, and to be on the alert for new symptoms if they should arise, thus forestalling the difficulties that might come up should the patient's condition change while on parole.

It is our opinion, therefore, that the more efficient the social-service department, the greater the number of patients who may be safely paroled and the more successfully will such patients be held on parole.

Thus far we have referred particularly to patients paroled to the custody of relatives, as they constitute the majority of our parole population. What can we do for patients whose relatives are not able, because of financial or other reasons, to assume their care?

Here, again, we call upon the social-service department for assistance. Occasionally we have been able, through friends of the patient, to secure suitable quarters and some sort of employment for him, but our greatest success has been accom-

plished in placing both men and women in general hospitals, where they are employed as porters, ward orderlies, elevator operators, waitresses, chamber maids, kitchen helpers, and so forth, at wages ranging from $10.00 to as much as $72.00 per month and maintenance.

Some of our markedly deteriorated chronic patients have for more than two years successfully held positions of this kind. At this date there are ninety-one patients on parole employed at the various general hospitals in Brooklyn and New York City, while fourteen discharged patients still hold the positions we originally found for them. Many of these are successful, not because they have recovered entirely from their psychoses—indeed, quite a few are still quite actively psychotic—but chiefly because a general hospital, being institutional in nature, approaches closely the environment from which they have just come. Furthermore, those in charge of these hospitals, being fully aware of the patient's condition, pay little if any attention to his eccentricities and have learned to humor them much as we do.

Our employment worker, who visits these various hospitals frequently, is called upon from time to time to adjust difficulties between employer and employed, but as a rule they get along exceedingly well, and we are told that our patient help is much preferred to the so called "floating employee" otherwise available for positions of this kind.

There are also innumerable demands for patients to perform domestic service in private families, but as these positions require the better class of more responsible patients, we are never quite able to meet the demand.

We have successfully placed a number of male patients in jobs on farms, but the majority of our patients are city bred and it is often difficult to induce them to accept employment of this nature.

Many patients originally placed by us in positions have, after becoming rehabilitated to extramural conditions, been able to go back to work at their former occupations and are now earning normal wages, while not a few whose relatives feared to give them a trial at home have, after proving their worth, been welcomed back to the family fold.

The unemployment that has prevailed for a year or more has militated against us; had the industrial condition of the country remained as it was in late 1919 and early 1920, we feel confident that we would have even better results to show.

Table 3 shows the number of months passed on parole by patients during the two years ending June 30, 1922:

Table 3. Length of Time on Parole of Patients Paroled During the Years Ending June 30, 1920 and 1921

Time on Parole	1920	1921
Less than one month	146	212
1 to 2 months	57	82
2 to 3 months	40	46
3 to 4 months	30	34
4 to 5 months	33	31
5 to 6 months	21	33
6 to 7 months	211	27
7 to 8 months	10	15
8 to 9 months	26	23
9 to 10 months	24	20
10 to 11 months	24	17
11 to 12 months	28	10
12 months	342	622
Total paroled patients	992	1,172

The large number of patients under the six-to-seven-months period in the year from July 1, 1919, to June 30, 1920, is explained by the fact that at that time many of our cases were discharged at the end of six months. As many remain out six months or more, and as not a few require return to the hospital between the six- and twelve-months period, we have recently been paroling practically all patients for one year. The above table indicates, we think, that the majority of our patients need our supervision for at least a year and many of them for an even longer period. This, we believe, justifies the adoption of the one-year-parole practice.

It is needless to say that repeated trials on parole should be made, as not infrequently our original judgment of the patient with relation to his environment may have been at fault. The following table shows the results of repeated trials:

Table 4. Repeated Trials on Parole From July 1, 1919, to June 30, 1921

Number of Trial	Discharged	On Parole	Returned
Second	91	12	113
Third	10	34	29
Fourth	1	12	7
Fifth	..	1	2
Sixth	..	1	..

Many of the patients above had trials previous to July 1, 1919.

These figures demonstrate that we are justified in giving patients a second, a third, or even a fourth, fifth, or sixth trial—under different conditions, of course—on the assumption that they will eventually fit properly into the environment provided for them.

A study of the parole activities at this hospital during the past two years shows us that from July 1, 1919, to June 30, 1920, 487 men and 505 women—a total of 992—were placed on parole. Of this total 91 were patients who escaped. Many of these, of course, remained on parole only a day or two, while others returned home and were regularly paroled to the custody of their relatives. Of the 992 patients, 883 were paroled to relatives or friends, 40 to employers, and 69 to general hospitals for employment.

During the year July 1, 1920, to June 30, 1921, 585 men and 587 women—a total of 1,172—were paroled, a gain of 180 over the number for the preceding year. Of these, 101 were escaped patients.

It was during this year that we began reparoling certain cases for an additional year, so that the total 1,172 includes 126 reparoled for a second year. This means, therefore, that we made an actual gain of only 54 over the number of new paroles during the preceding year. These patients, excluding reparoles, were paroled as follows: to relatives 786, to employers 99, to hospitals 161. Reparoled to relatives 93, to hospitals 30, to employers 3.

During the ten months of the current year—namely, from July 1, 1921, to April 30, 1922—there were 478 men and 374 women paroled, excluding reparoles, of which there have been 170. If the average rate is maintained during May and

June, we will have paroled approximately 1,200 patients during the current year.

Activities that result in such numbers of patients on parole of course require a great amount of work both inside and outside the hospital. The officers and employees of all the departments of the hospital are to be commended for the energy they have expended and the coöperation they have shown in carrying on this work within the hospital. At the same time, we must admit that without the untiring efforts of our social-service department in the field, such satisfactory results could never have been attained. The writer takes no credit to himself for the success of the work accomplished, except perhaps so far as the general organization and direction of the department are concerned, and therefore avails himself of this opportunity to compliment the field workers for their splendid work during the past two years. A brief description of the social-service department may be of interest:

As a definitely organized unit, with a corps of specially trained field workers and a physician in charge of its activities, the social-service department of the Kings Park Hospital has come into existence only within the last two years. In this short space of time, its function has become fairly well defined.

It occupies the position of an auxiliary to the medical department, under whose general control and direction its activities are conducted.

It is a recognized fact that to understand mental disorders one must study the patient, not only in cross section as seen on the hospital wards, but also in his social setting, thus obtaining some knowledge of the personal and human aspects of his condition. One must know him as he appears in his ordinary daily life, and study his emotions and his reactions in his difficulties as well as his pleasures.

It is this social knowledge concerning the patient that the social-service department has attempted to place in the physician's hands, thus broadening the scope of his resources in the way of treatment and adjustment and adding, so to speak, the human element to his scientific and technical view of his patients.

Through the information the field workers bring the physician, they often are able to make a valuable contribution to diagnosis. They may learn much as to the etiological factors upon which the prognosis of the case often depends, for frequently these upsetting factors, especially if they are of the environmental type, may be modified so as to permit of an early parole, and such modifications may prove a valuable background for rehabilitation.

The results of our parole work make increasingly evident the fact that the more intensive and intelligent the preparole preparation of the environment for the patient, the more successful the adjustment is apt to be. Many of our patients exhibit difficulties of adaptation that are, for the most part, associated with their respective settings of environment, habits, or temperamental friction, all of which may be corrected.

After the patient leaves the hospital, the social-service department becomes the sole means of contact of the hospital with the patient and here renders its most valuable assistance. In their regular visits to the homes of our patients, our field workers are able to watch carefully the reaction of the patient toward his surroundings, to scrutinize the attitude of the family toward him, and to give advice as to the best method of procedure in the treatment of any difficulties that may arise.

It is the function, therefore, of the field workers of this department to meet problems that involve family and social relationships, and by dealing with temperamental difficulties, peculiarities, disappointed ambitions, and the like, from a psychiatric standpoint, to render them harmless.

We have felt for a long time, perhaps unjustly, that members of the medical staffs of hospitals frequently pay too little heed to the recommendations regarding extramural adjustments made by the field workers, and to their decisions regarding the advisability of parole or the return of patients from parole. We should bear in mind that the intelligent treatment of mental disorders involves sociologic as well as medical problems, and that only through friendly coöperation and mutual understanding between the physician and the social worker can the best results be obtained.

In addition to the general field work outlined above, the

department operates two out-patient clinics, is not infrequently called upon to examine prisoners in the county jails of both Suffolk and Nassau counties, and more recently has taken up anti-syphilitic work, not only for patients on parole, but for the families of all syphilitic patients admitted to the hospital.

Table 5, which shows our activities during 1920 and during 1921, reveals how rapidly the work has grown:

Table 5. Extramural Activities, Kings Park State Hospital, for the Years Ending June 30, 1920 and 1921

	1920	1921
Visitors to clinics (all classes)	1,453	2,418
Visits to paroled patients	426	2,541
Other visits	164	745
Situations obtained	68	259
Letters written	431	1,860

In conclusion, we want to emphasize our opinion that the matter of granting parole must be a purely medico-social question, and that although there is an economic feature to be considered, the number of paroles should not be altered for the sake of economic advantages alone. Considering the first factor of parole, the patient's mental condition, we realize that desire alone cannot increase the number of recoveries from mental disease. The mental condition of the patient is a fact and cannot be altered because the taxpayers desire it.

The mental condition, however, is not the only element to be considered. Parole is also determined to a large extent by the possibility of securing a suitable environment outside the hospital. So far as recovered cases are concerned, the fact of recovery is the decisive point. But many paroles are possible without complete recovery, depending entirely upon the possibility of placing the patient under favorable conditions. It is, therefore, necessary to adapt the environment of the patient to his mental condition, so that our problem at once becomes social and educational as well as medical. Success in paroling increasingly large numbers of patients depends largely upon a proper adjustment of the patient's environment, the supervision given the patient at the hands of the

hospital, and the early recognition of the return of mental symptoms by the family, the employer, or the visiting social worker. In the case of chronic patients, we think that much could be done by carrying occupational therapy into the home. Where patients are not sufficiently recovered to compete in the industries, they might, having shown skill in basket weaving and the like, continue such work in the home. This, however, would necessitate an extramural occupational therapist, and this degree of organization we have not as yet attained.

We believe that a constant observation should be kept for patients with parole possibilities, and that wherever a patient is found whose symptoms do not contraindicate it, every effort should be made to arrange the extramural environment to receive him and to keep that environment adjusted to his needs through the constant supervision of a social worker. This, we contend, should be a state-wide policy.

Possibly, as has been recommended by the State Charities Aid Association, the organization of a state social-service department, whose function it would be to promote such a policy throughout the state-hospital system, would cause considerable saving to the state, and by relieving overcrowding as it now exists, would permit of more intensive work among those patients still in need of hospital care.

Given such a policy, we are of the opinion, judging from our own experience, that on a conservative estimate any state hospital could during each year parole between 15 and 20 per cent of its total population and could maintain a daily average of at least 10 or 12 per cent (exclusive of reparoles) on parole. To do this properly there should be not less than one field worker for each 100 patients on parole.

Reparole privileges should be increasingly liberal.

We have found little objection on the part of patients to reparoling for a second year; in fact we have not infrequently been requested by relatives as well as patients to continue the parole even to a third year. This, of course, we have not been doing, but we see no reason why there should be any set limit to the time a patient can be carried on parole, provided it is agreeable to all concerned.

ALCOHOLIC PSYCHOSES BEFORE AND AFTER PROHIBITION

HORATIO M. POLLOCK, PH.D.

Statistician and Editor, New York State Hospital Commission

THE only nation-wide information concerning alcoholic psychoses among admissions to institutions for mental disease available prior to 1919 is that contained in the Federal Census report on the insane in hospitals in 1910. On the schedules that were filled out for admissions during that year, the question was asked whether the patient was suffering from alcoholic psychosis. The term "alcoholic psychosis" was defined in the instructions for filling out the schedules as follows: "By 'alcoholic psychosis' is meant one of the mental diseases which, by their characteristic symptoms, are known to be the direct result of alcoholic intemperance. Cases of mental disease in which alcoholic intemperance is only one of the etiological factors and cases merely associated with alcoholic intemperance should not be reported under alcoholic psychosis."

Of the 60,769 patients with mental disease admitted to institutions in 1910, 6,122, or 10.1 per cent, were reported to be cases of alcoholic psychosis. The annual rate of admission of alcoholic cases was 6.7 per 100,000 of the general population. Considerable variation in rates was found in the several census divisions.

Table 1. Alcoholic Cases among Admissions to Institutions for Mental Disease in the Several Census Divisions, 1910

Division of United States	Per Cent of Total Admitted	Rate per 100,000 of Population
New England	12.9	13.7
Middle Atlantic	11.0	8.4
East North Central	10.0	7.2
West North Central	7.8	5.0
South Atlantic	8.0	4.4
East South Central	7.3	3.2
West South Central	8.1	2.7
Mountain	13.9	8.5
Pacific	12.7	10.5
Total	10.1	6.7

It was found by this census that patients with alcoholic psychoses constituted 12.4 per cent of admissions from urban districts and 6.4 per cent from rural districts. The rate per 100,000 of population in urban communities was 10.7 and in rural, 2.6.

Of the 34,116 males admitted in 1910 to hospitals for mental disease, 5,220, or 15.3 per cent, had alcoholic psychoses. Of the 26,653 females admitted, 902, or 3.4 per cent, were diagnosed as alcoholic. The rates per 100,000 population of same sex were 11.0 and 2.0 respectively.

The figures above cited for the Middle Atlantic Division correspond closely with those compiled by the statistical bureau of the New York State Hospital Commission for the year 1910.

In gathering data concerning admissions, the latter bureau separates first admissions from readmissions, as it is believed that the rate of first admissions constitutes a better measure of the incidence of mental disease. The yearly record of first admissions with alcoholic psychoses to the thirteen civil state hospitals of New York State since 1909 is as follows:

Table 2. First Admissions with Alcoholic Psychoses, Civil State Hospitals of New York, 1909-1921

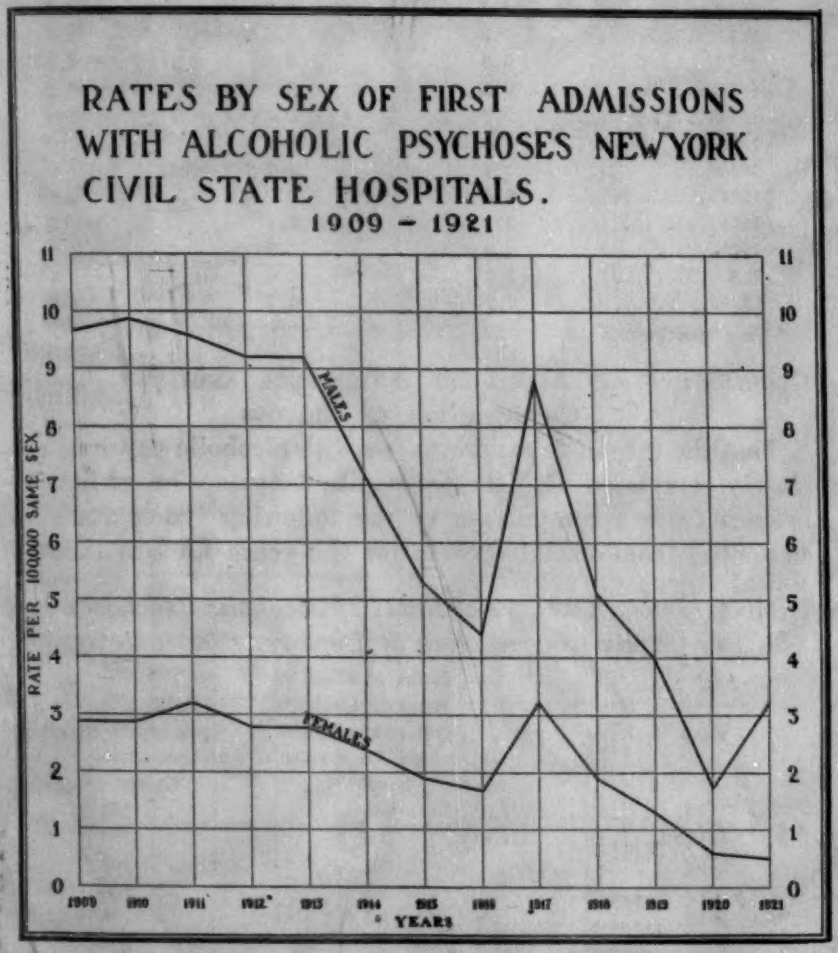
	Number			Per Cent of All First Admissions		
Year	Males	Females	Total	Males	Females	Total
1909.....	433	128	561	15.6	5.8	10.8
1910.....	452	131	583	15.3	5.0	10.5
1911.....	444	147	591	14.7	5.5	10.4
1912.....	434	131	565	14.4	4.8	9.8
1913.....	438	134	572	13.7	4.7	9.4
1914.....	348	116	464	10.4	3.6	7.4
1915.....	255	90	345	7.8	3.1	5.6
1916*.....	215	82	297	8.4	3.5	6.1
1917.....	437	157	594	12.1	4.8	8.6
1918.....	257	97	354	7.3	3.0	5.2
1919.....	204	65	269	5.8	2.0	4.0
1920.....	90	32	122	2.7	1.0	1.9
1921.....	167	26	193	4.6	0.8	2.8

* Nine months.

It will be noted from Table 2 that a marked decline in the number of alcoholic first admissions began in 1914 and be-

came more pronounced in 1915. In 1916 a slight change in trend occurred, and in 1917 a decided reaction took place, the number of alcoholic cases in that year exceeding that of 1913.

CHART I



In 1918, 1919, and 1920, the number of these cases fell off rapidly and reached its lowest point in 1920. In 1921 the male alcoholic cases increased, although there was a further reduction in female cases. The chart above shows graphically the rates for both sexes since 1909, based upon the general population. These rates are found in the following table:

Table 3. Rates of Alcoholic First Admissions to the New York Civil State Hospitals per 100,000 of the General Population of the State, 1909-1921

Year	Rate per 100,000 of General Population of Same Sex		
	Males	Females	Total
1909.....	9.7	2.9	6.3
1910.....	9.9	2.9	6.4
1911.....	9.6	3.2	6.4
1912.....	9.2	2.8	6.0
1913.....	9.2	2.8	6.0
1914.....	7.2	2.4	4.8
1915.....	5.3	1.9	3.6
1916*.....	4.4	1.7	4.0
1917.....	8.8	3.2	6.0
1918.....	5.1	1.9	3.5
1919.....	4.0.	1.3	2.6
1920.....	1.7	0.6	1.2
1921.....	3.2	0.5	1.8

* Nine months

Correlation of Alcoholic Admissions and Per Capita Consumption of Liquors

That the rate of first admissions with alcoholic psychoses is closely correlated with the per capita consumption of liquors is seen from a comparison of the following index numbers computed from official reports for the years 1909 to 1920:

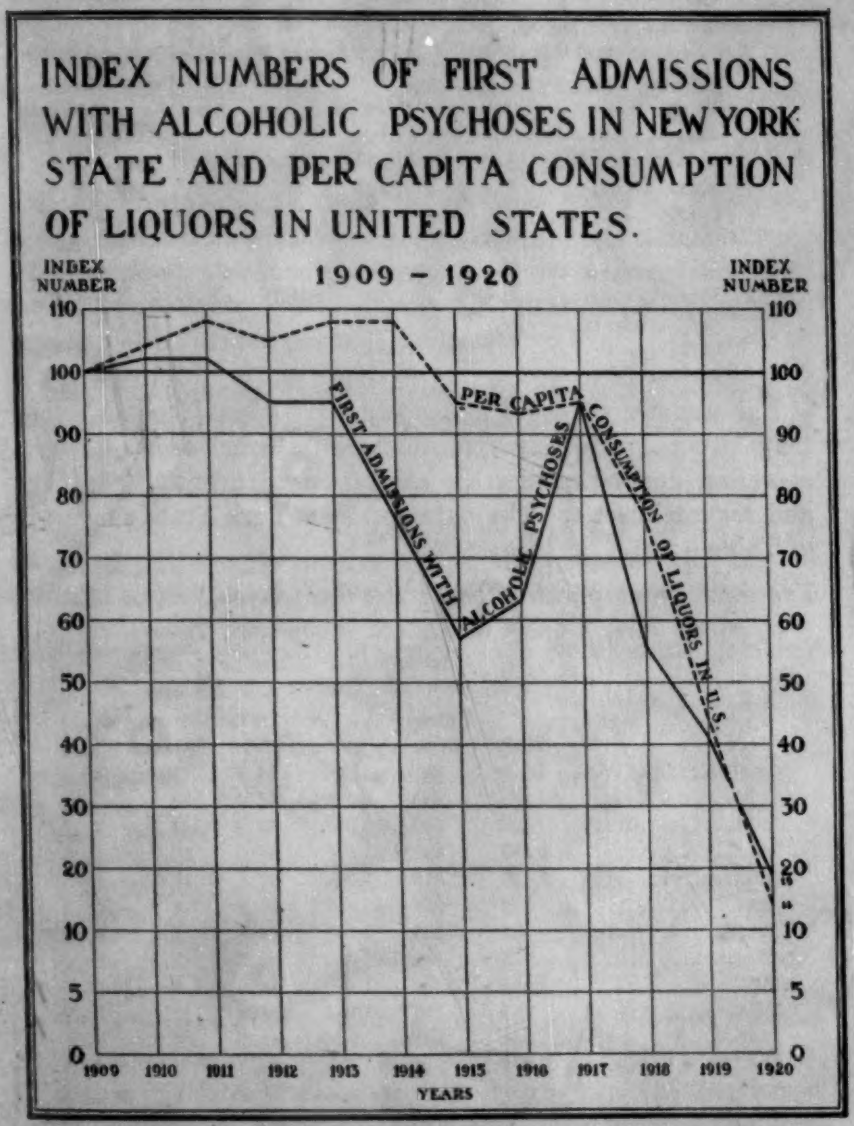
Table 4. Index Numbers of Rates of Alcoholic Psychoses and Per Capita Consumption of Liquors, 1909 to 1920

Year	Index numbers of rates of alcoholic first admissions to New York state hospitals	Index numbers of per capita consumption of liquors in United States
1909.....	100	100
1910.....	102	104
1911	102	108
1912.....	95	105
1913.....	95	108
1914.....	76	108
1915.....	57	95
1916.....	63	93
1917.....	95	95
1918.....	56	77
1919.....	41	44
1920.....	19	14

The coefficient of correlation between the two series of numbers is $0.875 \pm .045$. It is probable than an even closer

correlation would have been found had data relative to the per capita consumption of liquors in the state of New York been available. (See Chart II.)

CHART II



DECLINE OF ALCOHOLIC PSYCHOSES IN MASSACHUSETTS

The figures given above showing the decline in alcoholic psychoses in recent years in New York State are paralleled by data compiled from the official records of the state of

Massachusetts by Cora Frances Stoddard,[1] from whose study the following table is taken:

Table 5. First Admissions with Alcoholic Psychoses to Massachusetts State Hospitals for Mental Disease and McLean Hospital, 1912-1921

	Alcoholic First Admissions	
		Per cent of
Year	Number	total first admissions
1912	301	11.3
1913	367	11.8
1914	311	10.4
1915	299	9.5
1916	289	9.1
1917	511	12.3
1918	304	8.1
1919	296	7.8
1920	102	3.6
1921	151	4.9

The number of cases among all first admissions in which there is a record of intemperate use of alcohol shows a corresponding decline during the same period in both New York and Massachusetts. The data for New York State are given in Table 6:

Table 6. Intemperate Use of Alcohol Among First Admissions, New York Civil State Hospitals, 1909-1921

	Intemperate Users of Alcohol					
	Number			Per cent of total first admissions		
Year	Males	Females	Total	Males	Females	Total
1909	1,229	369	1,598	44.2	15.1	28.7
1910	1,684*	488*	2,172*	56.9	28.7	38.1
1911	1,082	302	1,384	35.9	11.2	24.3
1912	1,097	273	1,370	36.5	10.0	23.8
1913	1,103	318	1,421	34.6	11.1	23.5
1914	1,027	258	1,285	30.8	8.8	20.5
1915	939	225	1,164	28.8	7.5	18.7
1916†	725	182	907	28.2	7.8	18.5
1917	1,152	300	1,452	32.0	9.2	21.1
1918	851	253	1,104	24.1	7.7	16.2
1919	804	161	965	22.8	4.9	14.2
1920	684	119	803	20.3	3.7	12.2
1921	691	131	822	18.9	4.0	11.8

* Includes moderate drinkers.

† Nine months.

1 *Wet and Dry Years in a Decade of Massachusetts Public Records*, by Cora Frances Stoddard. *The Scientific Temperance Journal*, June, 1922, Vol. 31, pp. 1–54.

The gradual decline in the excessive use of alcohol indicated by the above table constitutes good evidence that a marked change in the habits of the general population with respect to the use of alcohol had been taking place for several years prior to the enactment of the Volstead Law. The change began before the World War, but was halted by the reaction of 1917. Later it was accelerated by war-time restrictions.

Alcoholic Admissions in 1921

The following tables, compiled by Miss Edith M. Furbush, Statistician of The National Committee for Mental Hygiene, from original standardized reports of state hospitals, give the latest available data concerning the prevalence of alcoholic psychoses in various parts of the country:

Table 7. Alcoholic Psychoses among First Admissions to State Hospitals in Fourteen States, 1921

State	Total First Admissions	Alcoholic First Admissions	
		Number	Per cent of all first admissions
California	2,459	110	4.5
Colorado	457	4	0.9
Maine	399	17	4.3
Massachusetts	2,538	130	5.1
New Hampshire	260	12	4.6
New Jersey	1,301	28	2.2
New York	7,104	210	3.0
Ohio	2,838	61	2.1
Pennsylvania	1,508	39	2.6
Rhode Island	329	19	5.8
South Carolina	740	9	1.2
South Dakota	193	1	0.5
Vermont	140	3	2.1
Virginia	1,315	24	1.8
Total	21,581	667	3.1

These representative data show that only 3.1 per cent of first admissions to state hospitals in 1921 were cases of alcoholic psychoses. Compared with figures previously given from the Federal Census of 1910 and the reports of the New York State Hospital Commission, a marked general decline in alcoholic insanity is shown. This is further evidenced by

the data of all admissions shown in Table 8, which is on nearly the same basis as the Federal Census figures:

Table 8. Alcoholic Admissions to State Hospitals in Fourteen States Compared with All Admissions and General Population, 1921

State	Total Admissions	All Alcoholic Admissions		Rate per 100,000 of General Population
		Number	Per cent of all admissions	
California	3,098	133	4.3	3.8
Colorado	480	5	1.0	0.5
Maine	490	20	4.1	2.6
Massachusetts ..	3,349	174	5.2	4.5
New Hampshire.	301	14	4.7	3.2
New Jersey.....	1,557	38	2.4	1.2
New York.....	9,235	255	2.8	2.4
Ohio	3,539	77	2.2	1.3
Pennsylvania ...	1,728	47	2.7	0.5
Rhode Island....	413	24	5.8	3.9
South Carolina..	938	10	1.1	0.6
South Dakota...	256	1	0.4	0.2
Vermont	197	3	1.5	0.9
Virginia	1,597	30	1.9	1.3
Total	27,178	831	3.1	1.9

It will be noted that the rate of admissions with alcoholic psychoses in these states was only 1.9 per 100,000 population, as compared to 6.7 for the whole country in 1910. During the year 1920, the first year under prohibition, alcoholic admissions to state hospitals were less than in 1921.

Table 9. Prevalence of Alcoholic Psychoses in Twenty States, 1919-1921

State	Number of Alcoholic First Admissions			Rate of Alcoholic First Admissions per 100,000 of Population		
	1921	1920	1919	1921	1920	1919
Arizona	*	3	..	*	0.9	..
Arkansas	*	8	5	*	0.5	0.3
California	110	*	*	3.1	*	*
Colorado	4	1	2	0.4	0.1	0.2
Connecticut	*	*	31	*	*	2.3
Georgia	*	9	9	*	0.3	0.3
Iowa	*	20	26	*	0.8	1.1
Maine	17	6	18	2.2	0.8	2.4
Massachusetts	130	91	295	3.3	2.4	7.8

State	Number of Alcoholic First Admissions			Rate of Alcoholic First Admissions per 100,000 of Population		
	1921	1920	1919	1921	1920	1919
Nebraska	*	*	6	*	*	0.5
New Hampshire	12	12	16	2.7	2.7	3.6
New Jersey	28	27	*	0.9	0.9	*
New York	210	143	285	2.0	1.4	2.8
Ohio	61	64	*	1.0	1.1	*
Pennsylvania	39	*	*	0.4	*	*
Rhode Island	19	14	19	3.1	2.3	3.2
South Carolina	9	5	6	0.5	0.3	0.4
South Dakota	1	2	..	0.2	0.3	..
Vermont	3	2	2	0.9	0.6	0.6
Virginia	24	21	30	1.0	0.9	1.3

* Data not available.

Table 9 gives comparative data for several states for 1919, 1920, and 1921. Although the table is incomplete, it shows considerable reduction in alcoholic admissions in several states from 1919 to 1920 and an increase from 1920 to 1921. The reaction in 1921 may be due to lax enforcement of liquor laws or perhaps in part to the economic depression.

Table 10. Sex of First Admissions with Alcoholic Psychoses in Twenty States, 1919-1921

State	1921			1920			1919		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Arizona	*	*	*	3	..	3	..	..	..
Arkansas	*	*	*	8	..	8	5	..	5
California	102	8	110	*	*	*	*	*	*
Colorado	3	1	4	..	1	1	2	..	2
Connecticut	*	*	*	*	*	*	27	4	31
Georgia	*	*	*	8	1	9	9	..	9
Iowa	*	*	*	20	..	20	25	1	26
Maine	16	1	17	6	..	6	17	1	18
Massachusetts	102	28	130	78	13	91	241	54	295
Nebraska	*	*	*	*	*	*	6	..	6
New Hampshire	9	3	12	12	..	12	15	1	16
New Jersey	25	3	28	25	2	27	*	*	*
New York	184	26	210	110	33	143	216	69	285
Ohio	57	4	61	60	4	64	*	*	*
Pennsylvania	34	5	39	*	*	*	*	*	*
Rhode Island	17	2	19	11	3	14	17	2	19
South Carolina	9	..	9	5	..	5	6	..	6
South Dakota	1	..	1	2	..	2	..	..	..
Vermont	2	1	3	1	1	2	2	..	2
Virginia	22	2	24	18	3	21	27	3	30

* Data not available.

Table 10 shows the sex distribution of the alcoholic first admissions in the several states. Relatively the decline in female alcoholic first admissions in 1920 and 1921 was more than in male cases. These results correspond with those found by Miss Stoddard[1] in her study of the effects of prohibition among women. She states: "The women have apparently gained more than the men under prohibition, perhaps because they are less exposed to the bootleggers' blandishments and are less likely to seek out the tribe. At all events, the average number of women in all penal institutions of Massachusetts on September 30, 1920 and 1921, the two dry years, was the lowest of the decade, 60 per cent smaller than the wet years' average, while the total prison population on this date had dropped 52 per cent.

"A decrease of practically one-half in the number of commitments to the State Reformatory for Women in the two prohibition years carries a stage farther the story, not only of the passing of the alcoholic women from penal institutions, but also of other women offenders."

Environment of Alcoholic Cases

During the entire period for which we have adequate data, alcoholic psychoses have been much more prevalent in urban than in rural districts. As previously mentioned, in 1910 the rates of all alcoholic admissions in the United States per 100,000 of general population of the same environment were 10.7 and 2.6 respectively. The admissions from urban districts in that year constituted 77.8 per cent of all the alcoholic admissions. Since 1910, the proportion of alcoholic cases from urban districts has increased. In a study[2] of first admissions to the New York civil state hospitals from July 1, 1915, to June 30, 1920, it was found that 90.9 per cent of the alcoholic first admissions were from urban districts. The average annual rate per 100,000 of general population was 3.7 in urban districts and 1.6 in rural districts. Representative data compiled by Miss Furbush from state-hospital re-

1 See note page 820.

2 *Mental Disease in Cities, Villages, and Rural Districts of New York, 1915–1920*, by Horatio M. Pollock and William J. Nolan. *State Hospital Quarterly*, November 1921, Vol. 7, pp. 38–65.

ports of several states in 1919, 1920, and 1921, show the following percentages:

Table 11. Environment of First Admissions with Alcoholic Psychoses, 1919-1921

(Representative data compiled from state-hospital reports of several states)

	Urban		Rural	
Year	Number	Per cent	Number	Per cent
1919.....	333	85.6	56	14.4
1920.....	400	83.9	77	16.1
1921.....	622	84.4	115	15.6

As the number and location of the state hospitals reporting were not identical in the three years, the above data are not strictly comparable, but indicate clearly the preponderance of cases of alcoholic psychoses in urban districts.

Conclusions

1. Marked reduction in the prevalence of alcoholic psychoses throughout the United States has taken place since 1910. This is due partly to restrictions on the liquor traffic and partly to changes in the habits of the people.
2. The lowest rate of first admissions with alcoholic psychoses occurred in 1920; a reaction occurred in 1921.
3. The rate of alcoholic first admissions is closely correlated with the per capita consumption of liquors.
4. The reduction in the rate of alcoholic psychoses has been relatively greater among women than among men.
5. Admissions with alcoholic psychoses come principally from urban districts.

THE SANATORIUM

SUSANNE HOWE

I. 4.45 a.m.—The Adirondack Special.

The vague, shrill howling of a lonely train
Far off among the soon-forgetful hills.
For night's revolting draft of fresh, red pain
The stale grey recompense of dawn again.

II. 12.30—The Dinner Gong.

Gaunt, trousered ghosts rise from the porch and go,
Obedient to a cheerful little bell,
To eat and drink, with lean jaws moving slow.
"How long, O Lord?" the only grace they know.

III. 5.00—Rest Hour.

The band brays on the main street where the corps
Of rookies drills before the gaping town.
The very trees stand higher to see more.
How is it that men know of just *one* war?

—Contemporary Verse.

THE PIONEER

ARTHUR GUITERMAN

Long years ago I blazed a trail
  Through lovely woods unknown till then,
And marked with cairns of splintered shale
  A mountain way for other men;

For other men who came and came:
  They trod the path more plain to see;
They gave my trail another's name,
  And no one speaks or knows of me.

Another's name my trail may bear,
  But still I keep, in waste and wood,
My joy because the trail is there,
  My peace because the trail is good.

—The Outlook.

ABSTRACTS

PROBLEMS CONFRONTING THE SECTION OF NERVOUS AND MENTAL DISEASES. By Peter Bassoe, M.D. *The Journal of the American Medical Association*, 78:1857-58, June 17, 1922.

In this paper, the chairman's address to the Section of Neurology and Psychiatry at the annual meeting of the American Medical Association last May, Dr. Bassoe reviews briefly the causes that have led to the great increase in public interest in neuropsychiatric problems, and emphasizes the fact that it is the duty of the medical profession to meet the new demand of jurists, educators, and the public in general for information and guidance, since "experience has shown again and again the importance of the medical point of view in connection with these problems". He warns the medical profession that it has no time to lose before facing these issues: "One has merely to observe the tables of contents of popular magazines and the subjects of lectures before clubs and public and private gatherings of all kinds to appreciate the extent of the invasion of the field of psychopathology by all kinds of lay psychoanalysts and psychologists, some of them well trained and well meaning, other dangerously contaminated by occultism, obscurantism, commercialism, or by all of these. Let us apply prophylaxis before radical treatment becomes necessary: We must persist in hammering on the necessity of teaching more psychology and psychiatry to medical students and of making these subjects compulsory for graduation."

Only by such training of physicians will it be possible to uproot one of the greatest difficulties in the way of neuropsychiatric prophylaxis—namely, the popular impression that there is a sharp line of demarcation between nervous disorders and mental disorders, that the latter are mysterious and terrible maladies appearing suddenly out of nowhere. Neurology and psychiatry, Dr. Bassoe believes, should be welded together in theory as well as in practice, since "a neurologist who is ignorant of morbid mental processes and a psychiatrist unfamiliar with organic nervous diseases are equally undesirable".

If the medical profession is to furnish advisors to the public in regard to problems that vitally affect human conduct, it is essential that it have the confidence of the public. For this reason, the profession in general and neurologists and psychiatrists in particular should work to eradicate an evil that has repeatedly brought the profession

into discredit with the public, and that is the present method of giving medical testimony in courts, particularly in cases involving questions of insanity and mental responsibility. Of this Dr. Bassoe says:

"The usual practice of each side selecting experts who appear in court with a partisan label has led to ills so well recognized that I will dwell on only one of them: the resulting public distrust of our opinions. We share this problem with all medical and other professional men, such as chemists and engineers, but we suffer relatively more damage to our reputations, as cases involving questions of mental responsibility are prone to attract a great deal of popular interest and to be exploited by the sensational press. Even the most discriminating lay people are tempted to question not only the exactness of the knowledge, but the common sense and sometimes perhaps also the sincerity of physicians giving testimony in such cases. If we do not always appear sensible and trustworthy when under oath to tell the whole truth, can we expect the public to trust us as advisors in their serious and intimate personal problems?"

As a first step in combating this evil, Dr. Bassoe recommends the adoption of a suggestion recently made by Dr. Herman Adler "that the American Medical Association create a council on medical jurisprudence 'whose main task shall be to work out and establish standards in this subject which can serve as guides not only for physicians, but for the legal profession as well'."

STUDY OF THE CASE PRELIMINARY TO TREATMENT. By William Healy, M.D. *Journal of Criminal Law and Criminology*, 13:74-81, May, 1922.

Dr. Healy feels that the present tendency in legal circles and among workers with delinquents to give up theorizing about such generalities as the question of heredity versus environment, the fact and age of responsibility, and so on, marks the first stage in the evolution of a new science, analogous to that phase of development in the physical sciences when they turned from attempts at classification and deduction from incomplete data to studying and experimenting with the materials and phenomena under discussion. The need for such a new science—a science of human behavior—is clearly indicated by the fact that theories with regard to the problems of delinquency—and there have been countless theories, theological, philosophical, sociological, biological, even psychological—all break down when it comes to handling effectually the definite, concrete problem presented by the individual delinquent, different in a thousand ways from every other delinquent.

Involving as it does matters of the utmost importance to the well-

being of all society and dealing with the most delicate organisms in the world—human beings—work in the field of juvenile delinquency demands the deepest scientific understanding, yet little attempt has been made to put it upon a scientific basis. In the first place, no particular professional training has been required of its personnel. In the second, no really adequate records have been kept by courts, probation officers, and corrective institutions—records from which it would be possible to draw conclusions with regard to the two plain, practical issues: (1) how the court can cope with various causes of delinquency and (2) with what reasonable expectation it can prescribe particular sorts of treatment when dealing with individuals who vary so widely in needs and possibilities that what will serve in one case will unquestionably fail in another.

There is a tendency to place too much reliance upon the establishment of a system—the probation system, for example—which may amount to nothing more than a routine procedure without any provision for meeting constructively the needs of individual cases. In this connection, Dr. Healy notes the recent attempt to take over a little psychological science, "with a jump at the idea that there can be handed out overnight a percentage statement which shall represent the so-called intelligence of delinquents, or at the idea that some few words of classification will tell a valuable story about the individual".

Again, the impression still prevails that it is the offense that must be treated rather than the individual offending—that certain types of offense call for reformatory treatment or removal from home, while others do not. As a matter of fact, a slight offense may be associated with significant behavior tendencies—meanness, cowardly lying, bad attitude toward parents, and the like—that can be brought to light only by a study of the case. On the other hand, an offense that is serious from the legal standpoint is not necessarily indicative of a trend toward criminality.

The worker with juvenile delinquents should know his material as the engineer knows his—how it will behave under various stresses and how it can be strengthened. Difficult as such knowledge is to attain in view of the complexity of the material, it is no more than fair that one who undertakes to handle such complex matters should "be in some position to answer the question of what this individual can do or is likely to do in education, in work, in conduct, or what is apt to take place if he is sent to this or that institution, or if he stays at home, or if he has special chances given him, and these points should be known early in the procedure with him for the sake of economic effort".

As steps in putting this work upon a more scientific footing, Dr. Healy makes the following recommendations: "(1) Better training of the personnel, beginning with the judges. (2) The placing of this whole work upon a professional basis through such training and through the education of the public. What has already taken place during ten or fifteen years shows the great possibilities in this direction, including the matter of adequate financial support. (3) The forming of an association of juvenile-court judges, meeting as other professional men, with closely knit interests, gathering together, not for the purpose of self-advertisement or presentation of superficial statements, but with the idea of gaining much from the experiences of others and from the interchange of scientifically worked up data concerning types of cases and other special problems. (4) The focussing upon the fact that the real results of effort in our field are to be measured by the nonrecurrence of delinquency; in other words, therapy is the aim, and cure is the measure of success."

TWO TWILIGHT ZONES IN HEALTH ADMINISTRATION. By E. R. Kelley, M.D. *American Journal of Public Health*, 12:563-67, July, 1922.

This paper is the presidential address delivered at the Thirty-seventh Annual Meeting of the Conference of State and Provincial Health Authorities, at Washington, May 15, 1922. Dr. Kelley feels that the tremendous expansion of public-health-administration work during the last twenty years, and the tendency to carry this work still further into every department of human affairs, make it necessary for public-health officials to consider carefully what should be the actual extent of their legal and moral jurisdiction in the development of personal and group hygiene. Certain functions, such as the control of communicable diseases, fall beyond doubt within the exclusive province of the official health department, but it is a question whether certain others, even though distinctly governmental, cannot be better administered by some other department of the government than the health department. It is a question, too, whether some of the more recently recognized health problems, which are now being handled by voluntary health societies, may not be for some time to come more adequately dealt with by such agencies than by a governmental department. Two of these border-line or twilight-zone public-health fields that are of great importance are those of school hygiene and mental hygiene.

School hygiene, in Dr. Kelley's opinion, has suffered greatly from a general confusion with regard to the proper division of duties between departments of health and departments of education. Func-

tions that in some places are performed by the health departments in others are carried on by the departments of education, and vice versa; and only too often the subject falls between the two stools and neither department has anything to do with it. The remedy for this condition is to make a clear distinction between the functions that have to do with the health supervision of school children and those that have to do with their health training or physical education, and to assign the one to the health departments and the other to the departments of education.

Mental hygiene as a public-health problem is in an even more nebulous state. Let alone the fact that it is only just beginning to be recognized as a part of the public-health movement, no attempt has been made to determine to what governmental department it properly belongs. Obviously it represents a far wider field than that at present covered by the state departments of mental disease, yet it is possible that such departments might be reorganized not only to include mental-hygiene work, but to make it the corner stone of all their activities. Again, since mental-hygiene work must be first and foremost work with children, it may be that it can best be developed and administered by the departments of education. And from another point of view, mental hygiene is a health problem, and there are good reasons for assigning it to the departments of health.

"The most significant characteristic of the entire subject of mental hygiene to-day, however, is that, generally speaking, neither departments of health, mental diseases, nor education officially recognize its existence.[1]

"Most commendable work is being done and great interest is being aroused in the subject in the two countries here represented, but entirely by voluntary societies and committees of mental hygiene. Individual members of governmental, psychiatric, educational, and health organizations are taking a keen interest in participating in the activities of these voluntary societies, but public opinion has not yet advanced to the point where the obvious next step, the active official participation of one or all of these departments in the work of mental hygiene, has been demanded.

"Because it seems quite clear that such a demand will be made in

[1] In this connection it is interesting to note that after the preparation of this paper two bills were introduced in the Massachusetts Legislature, one providing for changing the name of the Massachusetts Department of Mental Diseases to the Massachusetts Department of Mental Health, and the other creating a division of mental hygiene in the same department. The latter was approved and became a law, June 8, 1922; the former was referred to the next general court. These measures indicate a growing recognition of the need for official organized effort along the lines of mental hygiene.

the near future", Dr. Kelley concludes, "the time seems to have arrived when this subject should be given a prominent and permanent place in the deliberations of this conference. I earnestly recommend that we study this subject, solicit the assistance of representatives of voluntary societies for mental hygiene as advisory-committee members, solicit also the coöperation of educational and psychiatric officials, and thereby see if this conference cannot take the initiative in so shaping the development of this great and important phase of hygiene that the friction and misunderstandings that in the past have sadly marred and delayed the harmonious development of a continent-wide policy of school hygiene may be avoided."

MENTAL HYGIENE IN ITS RELATION TO PRESENT-DAY NURSING. By L. Vernon Briggs, M.D. *The Modern Hospital*, 19:236-40, September, 1922.

This is an urgent appeal to the nursing profession to devote more attention to the subject of psychiatric nursing. Dr. Briggs emphasizes the point that mental nursing is no longer limited to the care of the so-called insane and the feebleminded. As psychiatry begins to play a more and more important part in the fields of social and preventive medicine, there is an increasing demand for nurses with psychiatric training, not only in hospitals for mental diseases and general hospitals, but in industry, the schools, and public-health work in general. Moreover, the need for such training is not confined to those who intend to specialize in mental and nervous diseases—every nurse needs it; mental symptoms are often present in diseases that the general nurse is called upon to handle—indeed, every illness has its mental aspect—and a nurse is frequently hampered in her dealings with patients by lack of knowledge of the psychiatric problems involved.

The difficulty in interesting nurses in work with mental patients Dr. Briggs believes to be due to two causes—first, the old superstitious prejudice against the mentally ill that has lingered on from the dark ages, but is dying away as the realization grows that mental diseases are diseases like any other; and, second, the neglect of psychiatry in medical schools. Physicians who have not themselves been trained to recognize mental diseases have naturally not expected their nurses to understand mental nursing. This condition will remedy itself as psychiatry takes its proper place in medical education; the young general practitioner who has had psychiatric training will demand that his nurse shall know at least how to observe and report early mental symptoms and to care for incipient cases of mental disease. As physicians who desire to practice in Massachusetts are now

required to pass an examination in psychiatry, so, in Dr. Briggs' opinion, nurses should be obliged to qualify in psychiatric nursing before being allowed to register. He advocates also an exchange affiliation of the general hospitals with the state hospitals.

ORGANIZATION OF SOCIAL WORK IN A STATE HOSPITAL. By Mortimer W. Raynor, M.D. *The State Hospital Quarterly*, 7:319-25, May, 1922.

The author is director of clinical psychiatry at Manhattan State Hospital, and his discussion is based upon the organization of social work at that hospital. He assumes that social workers are assigned in the ratio of one to each one hundred patients on parole.

He classifies the various phases of the work as follows:

1. At time of admission of patients
   (a) Investigations to locate interested friends and relatives
   (b) Amelioration of home and family conditions
   (c) Gathering of social-history data
2. Follow-up work during hospital residence
   (a) Amelioration of home and family conditions
   (b) Development of plans for leaving hospital
3. Preparole
   (a) Investigations and establishing entrée with family
   (b) Report to physician
   (c) Adjusting of home and family conditions for the patient's return home
   (d) Securing of home or boarding house and a job
4. After-care
   (a) Supervision through clinics
   (b) Supervision through visits to home and plan of employment
   (c) Advice and assistance in maintaining adjustments, and promoting a salutory mental atmosphere in the home
5. Mental hygiene in community
   (a) Contact with other agencies doing social work, the schools, and correctional institutions and agencies, etc.

The discussion brings out clearly the fact that the work depends upon the close coöperation of physician and social worker. The latter interviews newly admitted patients and their relatives and friends, makes home investigations, and so forth, and the social data thus obtained are compiled and supplied to the physician for the patient's

folder, to assist him in understanding the patient and his needs. Plans for parole are formulated under the guidance of the physician; and when parole is actually under consideration, the social worker is equipped by the physician for her preparole investigation with a comprehensive outline of the case, including the patient's present mental and physical condition, the factors involved in his maladjustment, and the like. The results of the investigation—comprising full statements as to the type of environment to which the patient will return, his family and their attitude toward him and plans for him, and the social worker's own recommendations on the case—are reported back to the physician, who compiles from them a brief statement of the home situation, formulates the social problems involved, and adds his recommendations as to parole, with specific directions to the social worker on such points as amount and kind of supervision, employment, recreation, medical care, and the like. The case is then brought up for discussion at staff meetings, where final recommendations are made. When a patient is paroled, the social worker is supplied with full data on the case, including the staff-meeting discussions and recommendations. Parole patients reporting at clinics are interviewed both by physician and social worker, the latter making such home visits as are necessary, and throughout the parole period frequent conferences are held between physician and social worker, that every new situation may be met promptly and intelligently. So far as possible, especially after parole, one worker should follow a case through to its conclusion.

The experience of Manhattan State Hospital, Dr. Raynor concludes, "has shown the absolute necessity of supplying the social workers with full data concerning the patient's previous history, psychosis, and condition at time of parole and detailed and specific directions for meeting the problems of after-care. This in turn has necessitated the careful formulation of the social problems involved by the physician in charge of the patients."

WHAT PATIENTS MAY SAFELY BE PAROLED. By Russell E. Blaisdell, M.D. *The State Hospital Quarterly*, 7:311-18, May, 1922.

Writing from his experience with the parole system as first assistant physician at Kings Park State Hospital, Dr. Blaisdell divides the patient population of a hospital into three main groups: (1) those who are fit for parole under practically all conditions; (2) those whom it is unsafe to parole under any circumstances; (3) those whose cases call for careful study. Group 1 includes convalescent patients and patients who have not shown dangerous or untoward tendencies;

group 2, patients with suicidal or homicidal tendencies and patients who are restless, excited, depressed, violent, or destructive, or who require more skilled care than can be provided in a private home; in group 3, probably the largest of all, the advisability of parole depends not only upon the personality of the patient himself and the type of his psychosis, but upon the results of a thorough investigation of the environment to which he will go, the care and supervision that will be given him by relatives and friends or employers, and the efficiency of the hospital's social-service department.

Generally speaking, the parole list of a hospital will increase in proportion to the liberality of the management's point of view and the effort that is made to discover patients suitable for parole and to provide adequate supervision for them. "Both viewpoint and effort will vary greatly in different institutions as well as in the same hospital from time to time. This is well shown by comparing the average percentage of cases on parole from the thirteen civil hospitals of the state [New York] during any fiscal year. In the year ending September 30, 1914, the percentage varied from 1.84 in the lowest to 6.42 in the highest, while during the year ending June 30, 1920, the variation was still more marked, being from 2.30 to 11.50. At Kings Park the average percentage during the years 1913 and 1914 was 4.1 while during the last fiscal year it was increased to 13.4."

Every hospital probably contains large numbers of patients who have passed the acute phase of their illness and are no longer dangerous, but who for economic reasons, "and because of what has aptly been termed hospital inertia", have been kept in confinement longer than was necessary. Frequent surveys will disclose such patients in almost every ward of the hospital, including even those for disturbed or infirm patients. They may still show symptoms—hallucinations, bizarre notions, incoherency, odd behavior, and the like—but none of these is an absolute bar to parole. Dr. Blaisdell is convinced that there are comparatively few patients in civil hospitals who cannot be safely paroled under favorable conditions. He warns, however, that great care should be used in the selection of patients for parole, since there is always an element of hazard under any parole system; doubtful cases should be referred to the superintendent, upon whom the ultimate responsibility rests. Chances of unhappy results from an extension of the parole system will be reduced to a minimum by an efficient social-service department headed by a full-time physician, who should have entire supervision of patients through the parole period, conducting the clinics at which the patients report, having charge of the histories and social-service records, handling all correspondence, and directing the social workers' visits to patients. The

importance of reporting regularly at an out-patient clinic for observation and advice should be impressed upon the patients and their relatives, and patients who do not or cannot report should be visited by a social worker at their homes or places of employment.

THE LIBRARY IN THE MENTAL HOSPITAL. By Edith Kathleen Jones. *The Modern Hospital*, 18:535-36, June, 1922.

The author of this article is the former librarian of McLean Hospital, Waverley, Massachusetts. The mental hospital, she states, needs a pretty, cheerful library even more than the general hospital, since there are few bed patients in the former and the other patients are likely to be restless and eager to get away from the monotony of the wards.

The mental-hospital library can use a much better class of book than the library of the general hospital, whose patients, staying only for short periods and with minds wearied by illness or operations, usually want only the lightest of fiction. Mental patients, on the other hand, stay for long periods and are often in good physical condition and mentally alert. They are in many cases as much interested in the outside world as any one and frequently carry on courses of study or even conduct original research; consequently they want atlases, dictionaries, and reference books of all sorts. The great desire, however, is for fiction.

The selection of the books is all-important. The impression produced by a book is much deeper upon a mind in an abnormal condition than upon a normal mind, with its many interests and preoccupations. The mental patient may be depressed or excited or thrown into an agony of fear by books that would have little effect upon the ordinary reader. In choosing books for the mental-hospital library, therefore, the quality of "wholesomeness" is the one to which all others should be subordinated. To illustrate, the author gives the following list of "don'ts":

"Don't provide for mental patients stories having insane, degenerate, epileptic, or otherwise mentally affected characters; stories in which suicide is accomplished or attempted, especially if the means of suicide are carefully described (as in Wells' *History of Mr. Polly*); morbid or depressing novels, tales which deal with unhappy childhood, marital infelicities, physical deformities which warp a man's nature (like *Sir Richard Calmady*) or which end unhappily; sex-problem or erotic novels, though they be numbered among the best sellers; 'psychic', psychological, or self-analytical stories, however well written; ghost stories, because they never can have satisfactory endings and they haunt the patient; stories which have gruesome or

bloody details or which depict horror (Stevenson's *The Merry Men* and Conan Doyle's *The Hound of the Baskervilles* for example). In addition to this taboo fiction, discard most if not all books on psychology, religious discussion, law, medicine, and mental hygiene; never give a patient any books on these subjects without the approval of the physician in charge."

The books that should find place on the shelves of the mental-hospital library are clean, entertaining stories, fine, thoughtful novels, detective tales that dwell upon the skillful unraveling of the mystery rather than upon the details of the crime, nature books, books of travel and adventure, biographies, essays, poetry, and the like.

The selection of books for the individual patient is also important. If there is a librarian—"and without one the library is about as useless as a laboratory without a director"—she should study case records and talk over cases with doctors and head nurses, so that she may choose for each patient the books that are best adapted to his particular needs.

In addition to this work with individuals, there should be a carefully selected assortment of books in the sitting room of each ward, changed each week, and destructive patients should be given plenty of magazines and books not worth rebinding. Mention is also made of the value of reading aloud in wards of listless or depressed patients.

MEDICAL SERVICES MONEY CANNOT BUY. By H. E. Kleinschmidt, M.D. *Medical Review of Reviews*, 28:94-6, February, 1922.

The physician, especially the venereal-disease physician, is often confronted with situations that require the utmost tact and consideration, as well as judgment. A number of illustrative cases are given. Dr. Kleinschmidt points out the following guiding principles:

The psychological reaction of the patient should be anticipated and respected. Whereas bluntness may stir one individual to action, it may crush another of more sensitive fiber.

The physician must bear in mind the effects his answers may have on the family and the social relationships of the patient. The right answer involves an understanding of the mental make-up of the patient's relatives as well as of the patient himself.

Finally, the physician must always consider the possible effect of his answer on public health. Social obligations are to be considered as well as professional ethics. There is no such thing as a privileged communication when the health of others is endangered. The practice of medicine can be made a commercial enterprise or a profession, according to the motive of the individual physician.

BOOK REVIEWS

THE KINGDOM OF EVILS; PSYCHIATRIC SOCIAL WORK PRESENTED IN ONE HUNDRED CASE HISTORIES TOGETHER WITH A CLASSIFICATION OF SOCIAL DIVISIONS OF EVIL. By E. E. Southard, M.D., and Mary C. Jarrett, with an introduction by Richard C. Cabot, M.D.; a note on Legal Entanglement as a Division of Evil, by Roscoe Pound; and an appendix on Legislation in Relation to Mental Disease, by Frankwood E. Williams, M.D. New York: The Macmillan Company, 1922. 708 p.

There was a time, in the memory of psychiatrists who are not yet old, when psychiatry had but little contact with the rest of the world. This was when the psychiatrist was only an alienist, concerning himself mainly with "insanity" and discussing his subject matter entirely from the criteria of the insane hospital. This was as if zoölogists were concerned only with adult elephants and refused to talk about fetal or baby elephants and disregarded entirely the lesser living creatures.

It is not to be denied that there have been gallant figures in psychiatry who pushed boldly into other realms than their own. Though Morel, Esquirol, and the French school of psychiatrists may have been mistaken in their every conclusion, yet their generalization that neuropathy and psychopathy extend into crime, eccentricity, genius, and social disorder of all kinds was a fruitful one and brought into social thought, into society, the idea that conduct must be examined from the standpoint of the psychiatrist before it can be classed, condemned, or punished. This idea Lombroso elaborated, and Nordau extended, and extravagant and ill-founded as their conclusions, or rather premises, were, yet as a result of their teaching and preaching, psychiatry entered the fellowship of those disciples and sciences that seek to adapt man to the world and the world to man.

But generalizations and the impetus that comes from books solve but few individual problems, and it is individual problems in which the human being is mainly interested. Psychiatry remained in the insane hospitals; psychiatrists developed the medical side of their problems, evolved dementia praecox, manic-depressive insanity, separated out general paresis from the organic diseases, studied the pathological and serological relations of their science—basic efforts, indispensable, hugely important, but still without a great and notice-

able result upon society. There had to be evolved groups of workers who would be mainly interested in the social effects of mental disease, who would wonder why Mary Jones remained a prostitute and why Richard Roe remained out of work, who would labor to readjust this or that person to society, who would seek the advice and information necessary wherever it was to be found. In other words, the evolution of the social worker was necessary before the psychiatrist could penetrate into society and bring to bear upon its social problems his knowledge and experience. The approach of the psychiatrist to society and of society to the psychiatrist came through the social worker, and the locus of such coöperation between psychiatrist and social worker was necessarily some such nodal point of the Kingdom of Evils as the Psychopathic Hospital.

Before the psychiatrist could be so available, the traditional insane hospital, sequestered in its rural fastness, had to evolve into a metropolitan institution, freely accessible to every worker, interested in every problem of human maladjustment and misery, in touch with courts, doctors, relief agencies, into which there might flow a stream of cases representing all degrees and shades of mental diseases.

Such a hospital is the Boston Psychopathic Hospital, over which presided the lamented Southard, and whose social service was directed by Mary C. Jarrett. These two, surveying their experiences in this remarkable hospital, have written a book, *The Kingdom of Evils*, here reviewed, a book that cements psychiatry and social service in a union that nevermore should grow lax or be broken.

The Kingdom of Evils deals with a hundred unfortunates, into whose lives the five great evils of disease, ignorance, bad habits and vices, legal entanglements, and poverty, have entered in one form or another so as to bring them to the Psychopathic Hospital. In a simple narrative manner the authors set forth the history of each case, show how the patient came to the hospital, what was done, and what the result was. Though success is claimed where success was gained, failure is acknowledged with an unusual frankness, and throughout there are a modesty and a balance wholly admirable.

The technique of case description is essentially a layman's account, though written by Southard, the psychiatrist, pathologist, and philosopher. The analysis of each case is along obvious lines, no effort being made for subtlety, and I fear that Freudians will be quite disgusted with a work that considers sex only where it is obvious, and discusses complexes—almost not at all. We are introduced, not to people described with fine and minute detail, but to men and women drawn with bold strokes, and in relation to their main and obvious difficulties.

WOMAN, 43. LIVING AS MAN 12 YEARS

1916	*1916–18*
Man's dress	Woman's dress
Inebriate	Drinking spells
Irregular work	Steady job
Bisexual delinquency	Books and a pipe

Early history
Married. Deserted
Abandoned child
Put on disguise

Southard has taken these bold outlines of the case as furnished by Miss Jarrett and tells, in good Anglo-Saxon language, of Julia Brown, of her stock, of how she married a hard-drinking man who left her shortly after the birth of a baby boy. Putting the baby, whom she was never to see again, in his aunt's care, she went back to the mill and worked three years. In the late teens or early twenties, Julia Brown put on men's clothes and from that day forward never wore women's clothes again until she came under care.

"We have presented the case as one of non-medical and non-educational nature, although it would be easy to say that she is so far a victim of psychopathic personality that medicine has an important part in the plot, and it will also be easy to show that her life has been such that a part of her plight was due to ignorance. Nevertheless, we are not prepared to say that she is definitely a psychopath in the sense of sundry cases of overdeveloped instincts or of a definite psychopathia sexualis. She may belong, as hinted, in that wide and vague circle of eccentrics and cranks that lie in the limbo outside the circle of the psychopathias. Educationally, the woman is well informed and writes a good letter; there is no obvious gap in education to make up. On the other hand, there was, of course, a large moral problem and the question of readjustment of the entire attitude of this woman to her life. We have purposely laid little stress upon the sex delinquencies, heterosexual and homosexual, which are suspected or implicit in some parts of Julia Brown's history. With a case of congenital psychopathia sexualis, we question whether our social treatment would have been so relatively successful and so quickly productive of results as the above account indicates. In short, the readjustment problem was more a moral than a psychiatric one, despite the fact that the psychiatric point of view was no doubt of the utmost service in picking the situation to pieces and parting out the moral from the distinctly psychopathic elements of Julia Brown. The element of delinquency needs no further analysis than what the history reveals, and the economic problem, though never desperate,

required a good deal of help and indeed from time to time actual money grants.

Hours spent by	Medical record, 27 pages
	Social record, 48 pages
Physician, 5	Social work:
	Visits, 49
Psychologist, 1	Interviews at hospital, 14
	Telephone calls, 53
Social worker, 95½	Letters, 21''

And so we are introduced to Herman Simonson, ''intelligent clothes presser, disabled by occupational neurosis, large family in Russia to support'', who is finally adjusted by being given work as a porter; to Aimée Prevost, who is the ''heroine of a series of feigned suicides, whom the doctors called psychopathic personality, and who drifted away from the hospital; to Emma Marling, the ''overworked young mother harassed by scolding husband''; to Alice Nardini, ''a wayward syphilitic girl married to a black sheep; in the end a devoted mother''; and to many others, a hundred all told, whose human and medical problems enlisted the interest and efforts of psychiatrist and social worker. To those who, like the reviewer, have lived and worked in the Boston Psychopathic Hospital, the cases as they are recorded bring to memory the magic of the days when Southard reigned there—a busy place into which there poured a stream of hapless, helpless folk whose woes and disabilities made a representative cross section of the Kingdom of Evils.

The cases are presented in three books. The first, *The Three Major Spheres of Social Work, Public, Social, Individual,* tells of Agnes Jackson, a pathetic nuisance, whose problem embraces all three categories; of Richard Sully, a morbid altruist whose difficulties are public and social; and so on. Just here a difficulty presents itself to the reviewer, for it is not clear what distinction is to be made between public and social, and how any case can fail to be ''individual'' in its difficulties except in so far as one assumes a normal person caught in the swirl of adverse circumstances. Though one may quarrel with the separation of cases into these spheres (and the reviewer here records his difference of opinion), yet these cases are clearly presented and their treatment and fate candidly outlined.

Book two, *The Five Major Forms of Evil in the Regnum Malorum,* introduces us to the scheme underlying the title of the book. The evils are *morbi* (disease), *errores* (bad training), *vitia* (vice), *litigia* (law's entanglements), and *penuriæ* (poverty). The cases are presented according to the number of these elements that enter into them. Thus ''Rose Talbot, a highly intelligent delinquent (M. E.

V. L. P.), as the initial letters indicate was an intricate tangle of *morbi, errores, vitia, litigia,* and *penuriæ*—sick, poorly trained and educated, with vices and bad habits that entangled her in the law's meshes and poverty blackening the entire picture. Naturally there are those in whom all these constituents of the Kingdom of Evils are not present, and so we meet "John Flynn, industrial traumatic neurosis" (M. L. P.); "Eliot Calderwood, so-called little fiend, quite amenable" (E. L. P.); Kevork Ardinian, "work-or-fight" case whose problems are M. L.; and finally such cases as those of Clara Perkins, fabricator, mother of illegitimate children, who is declared to be the victim of V. (or vice), and Margaret Dolan, poor, old, and overworked, whose trouble is that only of poverty (P.). We defer a discussion of these forms of evil at this point because the authors (though Southard is undoubtedly the creator of the scheme) do not discuss it until Book IV.

Whatever else *The Kingdom of Evils* does or does not do, in its third part it sets forth, for the first time in the history of psychiatry, the social consequences of mental disease. Seven individuals with syphilopsychoses are depicted, not for their psychiatric or neurological significance, but for their social significance. We see them as they fail in their work or become changed in character, as they enter into police records, as they cause industrial accidents, as they become monkey wrenches in the social machinery. The hypophrenoses (feeble-mindedness) enter the lists of social maladjustment, not as adequately as their numbers warrant, but sufficiently to indicate that society owes part of its difficulties to the fact that some of its members are too "simple-minded" to keep up with its complexities. The epileptoses (epilepsies) come in for their bow on the stage of the Kingdom of Evils in the persons of five patients, one of whom developed epilepsy after alcoholism, another who killed his mother in a psychical equivalent, a third who caused difficulty in the army after being drafted, and two others whose attacks appeared to arise after inoculation in the army. (In the case of the last patient there is evident a somewhat too hasty conclusion that a patient is "better" because he improves for a time. He is cited—in 1918—as reduced in the number of attacks, whereas he is now—1922—as badly off as ever.)

King Alcohol and his allies in mischief, the narcotic drugs, are cited in the pharmacopsychoses as responsible in the main for the psychoses of a group of patients. Here we find it emphasized that alcoholism in itself is not psychiatric, a truth that needs to be hammered home to the minds of those who study heredity and class all alcoholism as neuropathic. Here we also find it emphasized that some alcoholism is neuropathic, and that the alcoholic psychoses are respon-

sible for tragedies of all kinds, from the impoverished home to the murder done by an alcoholic paranoiac. There is a wise sanity evident in the chapter dealing with alcohol and the alcoholic psychoses which the reviewer applauds the more heartily and the more enthusiastically because it is so rare in psychiatry and social work.

And so *The Kingdom of Evils* portrays, with emphasis on fact and much pertinent discussion of theory, the rôle of the encephalopsychoses (organic brain diseases), the somatopsychoses (body diseases), the geriopsychoses (senile psychoses) in their relation to social situations. Then the authors discuss the schizophrenoses (dementia praecox), the cyclothymoses (manic-depressive insanity), the psychoneuroses, and the psychopathoses. The medical point of view is stressed only as to diagnosis; for the rest the consideration of the case is largely from the point of view of the social worker and society. Though a philosophy is hinted at as behind the case presentation, it is mainly narrative, with some running comment, a sort of exhibition without profound analysis.

It is in Book IV, labeled *Epicrises,* that we come to grips with belief and theory. Southard claims much for psychiatry, but not too much. "When, therefore, we say we want to apply the psychiatric insight to practically the entire human world, we are not at all asserting or suspecting that the majority of human beings are in any sense psychopathic. We believe that more of the psychiatric point of view will be of great service to the world, as well in domestic as in political life. Just as James gave new viewpoints concerning the religious ecstasy, and just as Hippocrates and Galen before him were physicians who made the most extraordinary contributions to our knowledge of temperament, so we hope by the spread of the mental-hygiene point of view and the point of view of psychiatric social work to aid the common man and woman to deeper practical insights into everyday questions." With this as a program of psychiatry and psychiatric social work, the book emphasizes the value of individual study, the analysis of character as the start of an "inductive study which if carried on sedulously will react upon sociology itself and therefore upon political science, economics, ethics, and the rest of human interest".

There is a brief—to the reviewer unconvincing—statement of the reasons for the scheme of Book I, the division of cases according to the public, social, and individual spheres involved, which Southard ascribes to the influence of Professor Roscoe Pound. The argument for the division of the Kingdom of Evils into five types, the arrangement underlying Book II, is more interesting. Not too much is claimed for the division into *morbi, errores, vitia, litigia,* and *penuriæ.*

Pragmatism is the keynote of the Southard philosophy on this matter—"some division of data is better than no division". And Southard must have had his tongue in his cheek when, on page 391, he points out very gravely that it is very convenient from a mathematical point of view to deal with five divisions, rather than with four, six, or seven. The reviewer predicts that some other reviewer, who has not known the senior author of this book, will wax sarcastically indignant at a mathematical defense of the division of the evils of the world. But even an enemy or opponent will find it difficult to take seriously the *sinister* analysis of facts upon one hand, as outlined on page 393.

Southard rightly insists that we are not as yet ready to place ignorance and vice (*errores, vitia*) among diseases (*morbi*). Though some ignorance, some vice, is basically mental disease, perhaps the largest part is individual and social maladjustment, a wrong position of the gears of life rather than bad gears. And Southard dreams of the doing away of poverty through the unlocking of cosmic energies of research. We do not share his optimism in this regard and we feel that he has not deeply enough analyzed *penuriæ*. No one can disagree with the statement, "Man can no doubt form character more easily than he can reform character." The value of true education in a program of mental hygiene is well stated, though the place of ignorance in mental disease is, I believe, underestimated in this book. In fact, though useful as a division, it is well to remember that at no point can we separate disease, ignorance, crime, legal entanglements, and poverty from one another. Somewhere in the history of each disease is ignorance, crime, bad legislation, and poverty, and so with each of the constituents of the Kingdom of Evils.

The reviewer skips with a sigh the discussion of the nature of the evils or the analysis of history and historic movements on the basis of any pentad of evils or any psychopathic criteria. Too often does a man state the limitations of his science or art and then immediately overstep them. The chapter that deals with Book III commands our interest in its differentiation between the study of insanity and psychiatry, between the alienist and the psychiatrist. Southard brings to the lay worker and reader, as well as to the medical profession, the distinction between insanity as a legal pronouncement and mental disease as a medical diagnosis—between the alienist, who is to discriminate as a public official between sanity and insanity, and the psychiatrist, who is to discriminate between, treat, and study mental diseases. To the reviewer this differentiation is a happy one provided it will progress to the point where sanity and insanity will disappear from the thought of mankind; where the psychiatrist will have no

colleague, the alienist; where if legal entanglements arise, the expert will not be asked as to sanity and insanity—two nonexistent entities—but will be asked to diagnose the mental disease present and to state whether or not the law needs to act to protect society and the patient.

As psychiatrist Southard, as social worker his colleague, Jarrett, present the effects seen in society because of the mental disease of individuals. Obviously it is not sufficient to say that a man is insane or mentally sick; whether insane or not, it is necessary to add a diagnosis. Why? Say the authors, in effect, the social worker must deal differently with a dementia-praecox patient than with an epileptic, even though both break up the furniture or are thrown out of employment. If a patient be syphilitic, an issue is raised that is peculiar to syphilis—namely, has he infected his family?—and it becomes the bounden and sacred duty of psychiatrist and social worker to arrange for their examination and treatment as well as for the patient's treatment. Two men are paranoid, but one is so as the result of alcohol and the other because of a defective germ plasm; the social treatment is totally different in each case. And in dealing with any situation in which mental disease figures, the rôle of the psychiatrist is such that he must determine social treatment by his diagnosis, and that is why Book III of *The Kingdom of Evils* is all-important.

The last chapters of *The Kingdom of Evils* need no special analysis. They are useful and authoritative statements on the application of mental hygiene in the great war and in industry, on the use of technique of out-patient service, on psychiatric social work, its history and evolution. There is an interesting note by Roscoe Pound on legal entanglements, and there are appendices that deal with social records, social-service forms, and legislation in regard to mental disease. All these are of value, and especially is the article on legislation, by Frankwood E. Williams, of great value since very few know or care about the laws that govern psychiatric hospitals. Most of the chapters thus hastily mentioned are evidently written by the literary executors of Southard.

One wishes with Cabot, in his fine introduction, that Southard had lived to rearrange and condense the book. It seems as if Book IV should really have been incorporated as part of the other books, that its philosophy should have permeated their narrative; much repetition would thus have been avoided. There is much to criticize in this great book—from the title, which is more literary than descriptive or definitive, the quotations from Job that head its books, to the division of evils given so prominent a place in both the space and the thought of the book. It may be said by some, and with much truth, that the greatest evils of all, the disharmony existing between

man's nature and man's lot, between desire and taboo, between instinct and inhibition, the antagonism between the individual and the society man has created, are given no place at all. To this it might be replied that these evils are not a part of a social-psychiatric analysis, but belong to the psychopathologists and those who deal with the intricacies of the mental life of man. It does no injustice to the dead leader to admit that his book has great faults and some that were inherent in his nature. There was in Southard an eternal child, whose eager mind, finding new ideas, played with them, arranging and rearranging them as if they were toys.

But all these faults are as nothing to the virtues of the book. Whether we call it *The Kingdom of Evils* or *Psychiatric Social Work*, the fact is not altered that it presents the union of psychiatry and social work as no other book even begins to do. Whether we cavil at quotations from Job or find them appropriate is not pertinent to the fact that here psychiatry leaves its fastnesses in the asylums of the world and brings its knowledge to bear on the evils of life, and brings the evils of the world to bear on its own knowledge. For if the psychiatrist has something that he can teach to social worker, lawyer, judge, warden, and military man, he has much to learn from them to round out his psychiatry, and this is emphasized continually in *The Kingdom of Evils.*

From now on it should be impossible for society to do without the psychiatrist and for the psychiatrist to do without the social worker. From now on no hospital for mental disease but must have an outpatient department reaching out into its community, accessible to the community, acting as a great consulting room to court, social agency, and the harassed individual. But also it must organize a department of social work, to penetrate into the community, to act as an avenue of information, an avenue of operation, to bring the community to the hospital and the hospital to the community, to represent the psychiatrist to the patient and the patient to the psychiatrist. The social worker, properly viewed, and as represented in Southard's Jarrett, is no mere subordinate of the medical man—she is the great intermediate professional, linking him to the community, so that he as well as she may properly serve it.

ABRAHAM MYERSON.

Tufts Medical College.

MENTAL DISEASES: A PUBLIC HEALTH PROBLEM. By James V. May, M.D. Boston: Richard G. Badger, 1922. 544 p.

Whatever can aid in giving a wider appreciation of the important part that mental disorders play in our civilization must commend itself to the readers of MENTAL HYGIENE. Those whose main interests

lie in the field of psychiatry are familiar with a large amount of information that, could it gain more general attention, would arouse the public to an appreciation of the causes and nature of many of the social and health problems that are troubling our civilization. Much of this information is already in print, but lies buried in textbooks of a highly technical quality, or is so scattered through the literature as to be inconvenient for reference, or lacks an effectively coördinated presentation. With this in mind, Dr. May has given us the present volume.

The author brings to his task a rich experience with mental disorders in varied relations, accumulated during his work as physician and medical superintendent in hospitals in New York and Massachusetts, two states that have evolved exceptionally high standards in the care and treatment of the mentally disordered. As a commissioner of the state hospitals of New York, he had unusual opportunities to become familiar with problems of administration and legislative policies as they concerned the state as a unit. He is well known as one who has had a deep interest in the study of the statistics of mental disorders, and as having done much to promote coöperation among hospitals in their medical work. These qualifications of the author and an attractive method of presentation make this book one of authority and interest.

The contents are arranged in two divisions. The first is devoted to a general consideration of mental disorders as social problems, and the second to a consideration of the special clinical groups and types in which mental disorders occur.

The first chapter presents an array of statistical data, critically selected from authoritative sources, to show the economic and social importance of mental disorders. To emphasize his thesis that mental disorders are problems of public-health concern, the author discusses the statistics he presents in comparative relations with those of somatic diseases that are recognized as public-health problems and for which active efforts at prevention and regulation have been made. Two other chapters bear on this general social aspect. In one the relation of immigration and mental disorders is considered, and in the other the interrelation of the abnormal and diseased mind with problems of criminal responsibility. This latter chapter is one of convenient reference for those who discuss problems of behavior in the effort to secure a better recognition of these interrelations by courts and public officials, and brings together into one coördinated presentation a great deal of information that lies widely scattered.

Those who are interested in securing proper legislative provisions for the care of the mentally disordered, and in the problems that a

state must consider in providing adequate modern facilities, will find helpful suggestions in the chapters on legislation and methods of hospital administration. These contain an excellent concise narrative of the history of the development of hospitals for the mentally disordered and of legislative policies. These form the background for a description of modern methods of treatment and administration in hospitals of high standards. It is an account of what has been done by the more progressive states of this country and should be an incentive to the improvement of the deplorable conditions that still exist in many states in which hospital facilities and legislation are far below modern standards.

One of the special features that has characterized psychiatric progress in this country in recent years is the effort to make the technical information accumulated in this field more widely available in public service. Several specific developments are the outgrowth of this spirit. The most noteworthy are the establishment of psychopathic hospitals, the mental-hygiene movement, and the part that neuropsychiatry played in the recent war. The close relations that the author has had with each of these developments gives great value to his discussions of them, in a series of special chapters, and adds to the book's comprehensive presentation of the field of modern psychiatry.

A chapter devoted to endocrinology and psychiatry is very helpful at the present time in furnishing a concise survey of modern trends of thought in this field. The introduction, into a book primarily dealing with psychiatry, of the discussion of a subject so specifically one of general medical interest shows how closely modern psychiatric problems are connected with the general field of medicine and physiology.

The final chapter of the first division of this book is devoted to a consideration of the classification of mental disorders. Few subjects of psychiatric interest have been more prolific of discussion during the progress of psychiatry than those of classification and terminology. While the nature of the problems involved in nosological distinctions prevents any possibility of finalities or ultimate perfection, constructive progress can be greatly aided by a common understanding of descriptive terms. Until recently, the experiences of hospitals for mental disorders were reported in varying ways, representing different conceptions of values, and thus have been unusable for purposes of compilation and correlation. Within the last few years an effort has been made to secure a coöperation in the accumulation of data that might form the basis for building up a knowledge of existing conditions. The adoption, by a large majority of institutions and organizations working with psychiatric problems, of a uniformity in their statistical work promises much for a better understanding of

the part mental disorders play in our social life and makes it possible to judge as to the efficiency of our present methods. This scheme of classification is fully described by the author and forms a guide that will be of help to those who are working with clinical problems.

The second division of this book is devoted to clinical psychiatry. In this the author discusses the various clinical groups and types in which mental disorders occur.

The method of presentation followed is such as to make special comment or criticism of theories or conceptions uncalled for. The author brings together in his discussion a critically selected material drawn from many sources and arranged to present a systematic treatment of each topic. It thus is representative of the best thought and contributions on each subject. Particular consideration is given to the historic development of the conception of each clinical type, and throughout the discussion the author consistently keeps in mind the public-health relations of each disorder.

Dr. May clearly states in his preface that the book is not intended to be used as a textbook. As one becomes familiar with its contents, one cannot avoid the belief that the final results of his work have given to us a book that has a most needed place in the teaching of psychiatry. For the medical student, as a book to follow during his college course of instruction, it needs supplementing by one in which emphasis is placed upon the concrete clinical facts with which the physician must be concerned, such as case descriptions, symptomatology, interpretation, and treatment. It will, however, be for him a helpful book of reference, the more so as he becomes interested in the relations of mental disorders to social and behavior problems. But psychiatry has relationships in college instruction that are not specifically medical. Such are those that must be considered in courses in sociology, economics, and legal relations. In all of these Dr. May's book should have a foremost place.

The book gains distinction from an introduction written by Dr. Thomas W. Salmon, whose rich experience with mental disorders in broad relations, in connection with his work with The National Committee for Mental Hygiene, qualifies him to speak of its merits with authority.

One may fairly state that in no one book in English hitherto available can there be found such a well-selected assemblage of information that is needed to give a comprehensive survey of the social and administrative relations of mental disorders. It forms a valuable handbook of reference for all who are interested in institutional work, in public administrative matters, or in the wide field of abnormal behavior.

A. M. Barrett.

State Psychopathic Hospital, Ann Arbor.

BENIGN STUPORS. By August Hoch, M.D. Edited by John T. MacCurdy, M.D. New York: The Macmillan Company, 1921. 284 p.

Thorough studies of this kind are rare in all branches of medicine. It is, therefore, gratifying to those interested in American psychiatry that this valuable volume should appear at this time. Clinical psychiatrists will find it necessary to be conversant with its contents in order to have a proper understanding of a group of cases that heretofore have been very inadequately treated in the field of psychiatry.

For an appreciation of the true value of this contribution to psychiatry a certain perspective is necessary. More than twenty-five years ago, Kraepelin's clinical groups of manic-depressive insanity and dementia praecox, among others, came into being. These diagnostic groups, as is well known, were based on observed symptoms. Among these symptoms, negativism, resistance, apathy, and stupor became irrevocably associated with dementia praecox. The search for so-called pathognomonic symptoms was carried on to an extreme degree, not only in Germany, but also in this country; and so when any of these symptoms was found, psychiatrists investigated no further, but rested with the diagnosis of dementia praecox.

Fortunately this restricted psychiatric outlook has not endured in America; but while it was in vogue, it made a deep impression upon the minds of psychiatrists, and for that reason benign stupors, as described by Hoch, have heretofore been associated in the minds of most psychiatrists with dementia praecox, especially the catatonic form. Doubtless thousands of cases throughout the country have been so designated. Doubt has been cast upon the genuine recovery of any of these cases. Indeed, during the pre-Kraepelinian period, stupors appear to have been more clearly understood than in later days, as indicated by the review of the literature in the concluding pages of this book.

Careful clinical observation, particularly by Kirby of the Psychiatric Institute of New York, brought about a change in the interpretation of these cases. In 1913, Kirby called attention to their benign character and suggested that they bore a relationship to manic-depressive insanity, although having a certain similarity to the catatonic form of dementia praecox.

Hoch and MacCurdy, with Kirby's study as a background, have now submitted a detailed and exhaustive study of benign stupors. They establish the stupor reaction as a distinct clinical entity. They describe a definite symptomatology. They indicate the thought content, in so far as a thought content can be said to exist in these conditions. They interpret the meaning of the reaction and, what is of

great significance, they show quite clearly that these benign stupors are all a part of manic-depressive insanity.

Their observations are ably illustrated by a number of case histories. Their conclusions constitute one of the most stimulating contributions to psychiatry that has appeared in recent years. Their method of presenting the subject is one that might be emulated by other writers in psychopathology.

In their typical cases, the cardinal symptoms are as follows: *Lack of affect* is most important. These patients are remarkably apathetic, and when the stupor is deep, practically no emotional response can be elicited. This apathy is to be distinguished from the depressive affect that exists in retarded depressions. *Inactivity* is another cardinal symptom. There is almost complete cessation of speech and of spontaneous muscular activity. *Catalepsy* may accompany this state, and *negativism* frequently exists to a marked degree. Another outstanding symptom is *interference with intellectual processes* to such an extent that the mind seems almost a blank. Memory is in abeyance even for striking experiences that may occur during the psychosis. The thought content, which may be gathered at the onset or during interruption, shows a peculiar preoccupation with the *theme of death*, which is not merely a dominant topic, but one of almost exclusive interest. Finally, certain *physical symptoms* accompany this stupor, such as skin and circulatory anomalies, loss of weight, and menstrual suppression, and a low fever may occur.

The symptoms enumerated above the authors believe to be quite as distinctive of benign stupors as flight of ideas, elation, and pressure of activity are of the manic state.

An extremely interesting part of the study is that which has to do with thought content. It is true that active mentation does not take place throughout the stupor, but by a study of many cases, all showing practically the same general trend of thought, particularly by a study of the onset, by retrospective accounts, and by observations during the stupor, the characteristics of the thought content have been made clear.

The authors have shown that these patients are preoccupied by one dominating topic—namely, the theme of death. They believe themselves either dead or about to die. They are in heaven or hell. They wish death, and even make suicidal attempts. In whatever form this theme is symbolized, ideas of death are the outstanding trend of thought—just as depressed cases are preoccupied to a great extent with ideas of unworthiness and sadness, and manic states with thoughts of power accompanied by elation.

Since death and rebirth ideas exist so universally in man's mental

history, it is perhaps not remarkable that these ideas should be utilized by patients in benign stupors. In any case, this is what the authors have found to be true. Their observation offers a very interesting instance of how psychopathology and ethnology are inseparable in their expression.

A study such as the above represents infinitely more time, attention to detail, and thought than a few paragraphs of review can indicate. In addition to what has already been discussed, every phase of benign stupors is dealt with. This includes diagnosis, treatment, malignant stupors as contrasted with benign stupors, physical manifestations of stupor, special cases, and, in closing, a review of the important literature on stupors.

SANGER BROWN, II.

New York State Commission on Mental Deficiency.

PSYCHOANALYSIS AND THE WAR NEUROSES. By S. Ferenczi (Budapest), Karl Abraham (Berlin), Ernst Simmel (Berlin) and Ernest Jones (London). Introduction by Professor Sigmund Freud (Vienna). London: The International Psychoanalytical Press, 1921. 59 p.

The war has had the effect, not only of arousing interest in nervous and mental disorders, but also of modifying the views held in regard to their etiology. On the one hand, it has led to a fairly general recognition of the importance of the psychogenic factor, and to this extent has been a victory for the Freudian school. On the other hand, it has, in the eyes of many, tended to discredit at least one of the principles of psychoanalysis—namely, the principle "that the driving forces which find expression in the formation of symptoms are sexual in nature, and that the neurosis is the result of the conflict between the ego and the sexual impulses which it has repudiated". This little book—consisting of four papers, three of them read at the Fifth International Psychoanalytical Congress, held in Budapest in 1918, and one, that by Ernest Jones, read before the Royal Society of Medicine, Section of Psychiatry, in the same year—is of interest as an expression of the reaction of Freud and his followers to these new facts which the war has brought out and to the opinions to which they have given rise.

The first paper, by Dr. Ferenczi, is "a critical survey of the literature on the war neuroses from the standpoint of psychoanalysis".

With the war there flamed up the controversy as to the nature of the traumatic neuroses—whether they were of psychical or of physical origin—a controversy in which those favoring a psychical explanation were unquestionably the victors. This being established, the

quarrel lay from now on between the supporters of the various psychological theories. Ferenczi reviews the various theories put forward and points out that they constitute an advance toward the teachings of psychoanalysis. At the same time, as more or less representative of the views of neurologists who up to a certain point have accepted the psychoanalytical point of view, we get the statement of Nonne that "Freud's idea of the almost exclusively sexual foundation of hysteria has been conclusively disproved during the war". To which Ferenczi replies, "We can no longer leave this unanswered which after all is only a partial denial of psychoanalysis; also we can very easily give the answer. The war neuroses, according to psychoanalysis, belong to a group of neuroses in which not only is the genital sexuality affected, as in hysteria, but also its precursor, the so-called narcissism, self-love, just as in dementia praecox or paranoia. I grant that the sexual foundation of the so-called narcissistic neuroses is less easily apparent, particularly to those who equate sexuality and genitality and have neglected to use the word 'sexual' in the sense of the old Platonic Eros. Psychoanalysis, however, returns to this extremely ancient standpoint when it treats all tender and sensual relations of the man to his own or to the opposite sex—emotional feelings toward friends, relatives, and fellow creatures generally, even the affective behavior toward one's own ego and body—partly under the rubric 'erotism', otherwise 'sexuality'."

In the paper by Dr. Abraham, this narcissistic theory is further elaborated. Why, he asks, is the predisposition to break down as a result of trauma greater in some than in others? Those who broke down were as a rule "labile people" before the war, especially as regards their sexuality. "In all of them, sexual activity was diminished, their sexual hunger (libido) being checked through fixations; in many of them already before the campaign potency was weak or they were only potent under certain conditions. Their attitude toward the female sex was more or less disturbed through partial fixation of the sexual hunger (libido) in the developmental stage of narcissism. Their sexual and social capacity of functioning was dependent on their making certain concessions to their narcissism.

"In the war these men were placed under completely changed conditions and in the face of extraordinary demands. They had always to be prepared for unconditional self-sacrifice in favor of the mass. This signifies the renunciation of all narcissistic privileges. The healthy person is able to accomplish such a complete suppression of his narcissism; he loves according to the transference type and so is capable of sacrificing his ego for the whole. In this respect those disposed to neuroses are inferior to healthy persons."

The paper by Simmel deals with his experience in treating war neuroses. His treatment consisted of "a combination of analytical-cathartic hypnosis with analytical conversations during the waking state and dream interpretations carried out both in the waking state and in deep hypnosis". With this method a relief of symptoms was brought about in two or three sittings on an average. He found that the unconscious meaning of the symptoms was "for the most part of a non-sexual nature, there being exhibited in them all those war-produced affects of terror, anxiety, rage, etc., associated with ideas corresponding with the actual occurrences of the war". Simmel does not conclude from these facts, however, that the war neuroses have not a sexual basis. "The fact that in the midst of the selfsame experiences one soldier remains well while another becomes a neurotic may, so far as my experience goes, be very well connected with the psychosexual constellation of the particular individual."

Ernest Jones, in his paper, in which he attempts to harmonize the facts brought out by the war with Freud's theory of the neuroses, expresses views more or less similar to those of Ferenczi and Abraham. He frankly admits that Freud's theory has not yet been proved true in the case of the war neuroses. This, however, is quite another matter from saying that it has been disproved. "The matter is at present *sub judice* and must remain so until sufficiently extensive investigations shall have settled the question one way or the other." However, although nothing is yet proved, the psychoanalyst should be able to formulate "some tentative conception of the relation between the phenomena commonly observed in the war neuroses and the psychoanalytical theory". He here undertakes to formulate such a conception.

There is in all of us a conflict between the conscious ego on the one side and various impulses and desires on the other, out of which, after a series of partial renunciations and compromises, an adjustment of some sort is reached. In warfare new conditions and new standards of conduct obtain; impulses previously held in check—impulses to cruelty, for example—are released, and a new adjustment therefore becomes necessary. "When the old adjustment between the ego-ideal and the repressed impulses is taken away, it may prove impossible to establish a fresh one on the new conditions, and then the repressed impulses will find expression in some form of neurotic symptom."

But aside from this question of war adaptation, we have also that of fear. "The latter is hardly to be regarded as a sub-group of the former, inasmuch as there is no readjustment or transvaluation of values concerned, as there typically is with the former. The moral attitude toward fear and the conflicts arising in connection with it

remain the same in war as in peace." How, then, is this fear to be explained? "The reaction to external danger consists normally of a mental state of fear . . . and in various activities suited to the occasion—flight, concealment, defense by fighting, or even sometimes by attacking. On the affective side, there is, to begin with, a state of anxious preparedness and watchfulness, with its sensorial attentiveness and its motor tension. This is clearly a useful mental state, but it often goes on further into a condition of developed dread or terror which is certainly the very reverse of useful, for it not only paralyzes whatever action may be suitable, but even inhibits the functioning of the mind, so that the person cannot judge or decide what he ought best to do were he able to do it. The whole reaction of 'real' fear is thus seen to consist of two useful components and one useless one, and it is just this useless one that most resembles in all its phenomena the condition of morbid anxiety." Jones infers, therefore, that this useless component "is not part of the useful biological mechanism of defense, but is an abnormal response akin to the neurotic symptom of morbid anxiety".

Now practically all modern investigations into the pathogenesis of morbid fear "agree that it stands in the closest relation with unsatisfied and repressed sexuality", and "Freud has made the striking suggestion that the developed dread sometimes found in situations of real danger is derived, not from the repressed sexual hunger that is directed toward external objects, as in the morbid anxiety of the peace neuroses, but from the narcissistic part of the sexual hunger that is attached to the ego". Jones, therefore, "ventures to suggest that we may here have the key to the states of terror with which we are so familiar in the war neuroses", and reaches "the comforting conclusion that a normal man would be entirely free from dread in the presence of any danger however imminent, that he would be as fearless as Siegfried".

One wonders how Dr. Jones would apply this theory to the facts of animal psychology. We not infrequently see animals, horses for example, overcome by terror which, as in the case of men, "is certainly the reverse of useful" and which "paralyzes whatever action may be suitable". Would Dr. Jones explain this reaction on the part of a horse in the same way as he does a similar reaction on the part of a man? Would he regard the dread displayed by the horse which "is not part of the useful biological mechanism of defense" as due to unsatisfied narcissistic hunger, and would he reach the same "comforting conclusion" that a normal horse "would be entirely free from dread in the presence of any danger however imminent, that he would be as fearless as Siegfried"?

The introduction, by Freud himself, may logically be considered

last, since in it are summed up the views expressed by the other writers. Freud grants, as does Jones, that the sexual-hunger (libido) theory of the neuroses has not been proved as regards the war neuroses, and also lays great stress on the fact that neither has it been disproved. He believes that there is a correlation undoubtedly subsisting between shock, anxiety, and narcissistic sexual hunger (libido).

"The theory of the sexual etiology of the neuroses or, as we prefer to call it, the sexual-hunger (libido) theory, was originally put forward only as regards the transference neuroses of peace conditions, and can easily be demonstrated in them by using the analytic technique. But its application to those affections which more recently we have grouped together as the narcissistic neuroses meets with difficulties. Ordinary cases of dementia praecox, paranoia, and melancholia are fundamentally very unsuitable material for the proof of the sexual-hunger (libido) theory and for reaching an understanding of it, for which reason psychiatrists who neglect the transference neuroses cannot be reconciled to it. The traumatic neuroses (of peace time) have always been reckoned to be the most refractory in this respect, so that the appearance of the war neuroses does not add any fresh factor to the former situation.

"Only by advancing and making use of the idea of a 'narcissistic sexual hunger (libido)'—that is to say, a mass of sexual energy that attaches itself to the ego and satisfies itself with this as otherwise it does only with an object—has it been possible to extend the sexual-hunger (libido) theory to the narcissistic neuroses, and this entirely legitimate development of the concept of sexuality bids fair to do for these severer neuroses and for the psychoses all that one can expect from an empirically and tentatively progressing theory."

This broader concept of sexuality on which the psychoanalyst so strongly insists may be, as Freud says, entirely legitimate, but it is rather hard to see just how it enables us to establish a sexual basis for the war neuroses along the lines of psychoanalytical theory. It is a principle of psychoanalysis, as stated by Jones in the present volume, that the wish that leads to the creation of the neurosis is an unconscious one—"the wish producing the neurosis is one that is not in harmony with the ego-ideal and that is therefore kept at as great a distance as possible from it". So it would appear that if the love of the individual for himself, his parents, and his fellow men, is to serve as an etiological factor in the production of the neurosis, it must, according to the psychoanalytical theory, be a force that conflicts with the ego-ideal, a force, therefore, of which the individual is not conscious. Now the love of man for his fellow men and of a child for his parents is universally regarded as a virtue, and as far as self-

love or regard for one's own welfare is concerned, if not regarded as a virtue, it is at least accepted as a natural tendency common to all men, the absence of which in any individual would be clear evidence of abnormality.

Those forms of love for one's self or for one's fellows which the psychoanalyst has taken in by broadening his conception of "sexuality" do not, therefore, conflict with the ego-ideal, nor are they crowded back into the unconscious. The forms of love that are looked upon as immoral, and that therefore conflict with the ego-ideal so that they are likely to be repressed, are with few, if any, exceptions those that we look upon as "sexual" in the old narrow meaning of the word, and it is therefore such forms of sexuality only that, according to the principles of the psychoanalytical theory, can give rise to a neurosis. Since, then, it is only these forms of sexuality that can give rise to a neurosis, it is not quite clear how broadening the meaning of the term can enable us to find a sexual cause for those forms of mental and nervous disorder in which no such cause could otherwise be found. It would almost seem as if the psychoanalyst had here fallen into the logical error of carrying over into the broader meaning of the term "sexuality" an implication that belonged only to that narrower conventional meaning which he had discarded; that, in short, he was giving the word "sexual" a very broad meaning in order to demonstrate the existence of a sexual wish and then falling back on the old narrow meaning of the term in order to make of this wish something that might serve as the dynamic factor lying back of the neuroses.

The concept of "sexuality" has been broadened to include "narcissistic sexual hunger", but no explanation is offered of how this "narcissistic sexual hunger" comes into conflict with the ego-ideal and of how, therefore, it can be the dynamic factor in the production of the war neuroses. "Narcissistic sexual hunger" is a very fine term, but one might wish that those who use it would be a little more specific in explaining just what it is and how it operates. The term hunger implies always that there is something for which the individual hungers, something wished for or desired. What is this something in the case of "narcissistic sexual hunger (libido)"? In the case of sexual hunger directed toward another individual, whether of one's own or the opposite sex, the wish may be for some form of sensual gratification recognized as sexual in the old narrow meaning of the term, but it is not in this old narrow meaning that the term is here used. One who loves another may also wish to have his love reciprocated or to have his loved one always with him, but the narcissistic lover has this advantage over all others that he can never by

any possibility suffer from unrequited love, nor can he ever be separated from the object of his regard. One may also desire the happiness and well-being of his loved one, and it is of course true that under war conditions the soldier may be obliged to place service to the group before his desire for his own welfare, which, as every one admits, does give rise to an emotional conflict. But although he may be unable to gratify it, the soldier does not therefore look upon his wish for his own welfare and safety as in any sense an ignoble or an improper one; it does not conflict with his ego-ideal, and, speaking from personal experiences of life at the front under shell fire, the reviewer might say that one is seldom unconscious of this wish. What, then, is the nature of the narcissistic wish which the soldier is unable to gratify, of which he is unconscious, and which therefore is capable of giving rise to a neurosis? The question is one in regard to which the advocates of the "narcissistic sexual-hunger (libido)" theory have very little to say and which we would like to have answered.

Our review of this book would be incomplete if it dealt only with the reaction of its authors to the facts brought out by the war neuroses and neglected to make any mention of their attitude toward those whom they look upon as their opponents. With the exception of Dr. Simmel's paper, we find displayed throughout the tendency, so prevalent amongst psychoanalysts, to charge those who differ from them with intellectual dishonesty and ignorance. Freud speaks of "the opponents of psychoanalysis, whose repugnance to sexuality has shown itself to be stronger than their logic", and Jones asserts that those who deny the doctrines of psychoanalysis, and who presumably have never themselves employed any method that gives access to the unconscious, are "in a very similar position to the individual who on *a priori* grounds would deny the details or even the existence of histology without having looked through a microscope, the only avenue to histology".

"Many medical men", says Freud, "who had previously held themselves aloof from psychoanalysis have been brought into close touch with its theories through their service with the army compelling them to deal with the question of the war neuroses. . . . Some of the factors, such as the psychogenetic origin of the symptoms, the significance of unconscious impulses, and the part that the primary advantages of being ill plays in the adjusting psychical conflicts ('flight into disease'), all of which had long before been discovered and described as operating in the neuroses of peace time, were also found in the war neuroses and almost generally accepted. . . .

"From the advance thus made towards psychoanalysis, however,

one need not assume that the opposition to it has been reconciled or neutralized. One might think that when a man who had hitherto not accepted any of a number of connected conclusions suddenly finds himself in the position of being convinced of a truth of part of them, he would weaken in his opposition and adopt an attitude of respectful attention, lest the other part, of which he has no personal experience, and therefore upon which he is unable to form a personal opinion, should also prove to be correct."

Freud's position is cleverly taken and is without doubt more or less justified as regards certain of his opponents. There are, however, others who might reply that they had already held views before the war which in some respects were in agreement with those of Freud, although they had been unable to accept his theory that the driving force lying back of the symptoms was in every case of a sexual nature. Such individuals might well claim that the war neuroses had simply afforded additional evidence in support of an opinion that they had held right along. And of the converts whom the war won over to a similar opinion, not all came from the ranks of those who before the war had denied the existence of psychogenic factors in mental disease. Some at least were men who had previously accepted the doctrines of psychoanalysis in their entirety, but now felt it necessary to modify their position somewhat.

It is an unfortunate thing that the psychoanalyst should adopt such an intolerant and partisan attitude towards those who differ from him. Undoubtedly it is partly due to the fact that in the past he has encountered much unjust criticism that had its roots in prejudice and ignorance. At the present time, however, here in America at least, there are comparatively few who refuse to recognize the fact that in the field of abnormal psychology, Freud and his followers have done valuable pioneer work, or who are unwilling to make use of the theory and technique of psychoanalysis, in so far as they find this theory and technique adapted to the problems with which they have to deal.

MILTON A. HARRINGTON.
New York City.

FUNDAMENTAL CONCEPTIONS OF PSYCHOANALYSIS. By A. A. Brill, Ph.B., M.D. New York: Harcourt, Brace, and Company, 1921. 344 p.

In the introduction to this book, Doctor Brill states: "Moreover, the knowledge gained through it [psychoanalysis] is developing a prophylaxis which will not only diminish nervous and mental diseases, but will establish newer methods in our system of education. In brief, psychoanalysis, aside from its therapeutic application, which

is not the object of this work, is of interest to any person who wishes to understand human nature and know himself in the Socratic sense." So, too, Dr. Brill emphasizes constantly throughout his dissertation the necessity of understanding one's self as well as one's relation to society.

As a presentation of the facts, the principles, and the truths of Freud's foundations and mechanisms, this work is unsurpassed, and great credit should be given to Dr. Brill for his tireless efforts to bring this subject in its true form before not only the medical profession, but also the public in general.

The first chapter gives a resumé of the steps taken by Freud and Breuer in the development of the technique that was termed by them the cathartic method. Through this method it became evident that the so-called normality or abnormality of the individual—the question whether he will be able to adjust himself to his environment or will fall by the wayside—depends entirely upon the nature of his early impressions. "Given an average amount of brains, every individual, as he grows up, has certain tracks laid out for him by his environment; he can follow those tracks and those only; if he attempts to get off the track, he finds himself in trouble; he finds himself incompatible with his environment, he collides with his environment. It is thus of great importance to give the individual enough tracks to be able to move freely and at the same time not to come in conflict with his fellow beings. From a very broad experience with nervous and mental diseases, I feel that if everybody would understand this, mothers and teachers particularly, we could reduce nervous and mental diseases as much as we have reduced diseases of smallpox and typhoid. We are not afflicted with these time-old diseases to-day because we know what produces them and have learnt to prevent them. We can do likewise with a knowledge of psychoanalytic principles."

Doctor Brill has then applied the knowledge of psychoanalytic principles to the interpretation of symptoms, their nature and function. Their nature is that of a defense and their function is that of an emotional outlet. The technique of psychoanalysis offers a means whereby the symptom may be understood, and the cure of a symptom would bear a constant relation to the release of the emotion through adequate channels. The mere fact that analyzing an individual is quite different from curing an individual of a disorder should be obvious.

The psychology of forgetting, the psychology of everyday life, and the technique and tendencies of wit are discussed in detail and with clearness.

The chapters on dreams are devoted to an explanation of the functions and motives of our dream life. Many extremely interesting and carefully analyzed dreams are offered to the reader. A careful study of the mechanism of dream states leads one to recognize the very definite and close relation of the dream—as was shown of symptoms, too—to the inner life of the patient. Both dreams and symptoms are "incursions into consciousness from the unconscious", and "it is necessary to get at what we called their 'latent' contents to grasp their essential significance and meaning".

Throughout the book it is demonstrated frequently that much of our conduct reaction and our behavioristic responses bear a close relation to our "love" life, controlled, guided, and directed by our unconscious personality and its relation to our environment.

An excellent description of the only child is given in detail. Dr. Brill says: "The problem is more complicated when we come to prophylaxis in relation to psychosexuality . . . I shall merely say that proper sex regulation does not necessarily imply repression and extermination of all sex feelings, and that the requisites for perfect manhood and womanhood are all the impulses and desires that are normally common to men and women . . . the only child is a morbid product of our present social-economic system . . . by their [parents] abnormal love they not only unfit the child for life's battles, but prevent him from developing into normal manhood, thus producing sexual preverts and neurotics of all descriptions."

The last two chapters, on fairy tales and the selection of a vocation, can best be described in Dr. Brill's own words: "We may thus lay it down as a general principle that all expressions, whether normal or abnormal, as symptoms, dreams, witticisms, fairy tales, and artistic productions, may be classified as infantile or adult, or as auto-erotic or object libido. Inherently, there is very little difference as far as the individual is concerned, but conceived socially, we may say that only those productions that have meaning and effect to others besides the artist or producer himself may be considered normal."

As a presentation of the principles of psychoanalysis as laid down by Freud, the author has given us an excellent expression. He has also offered to the psychiatrist, and to others interested in mental hygiene, an implement of great usefulness. To the student of human nature, to the educator and teacher, and to those whose work brings them in contact with children, this book offers valuable assistance in the understanding of conduct disorders. It is an exceptionally good book.

FREDERIC J. FARNELL.

Rhode Island Society for Mental Hygiene.

THE ORIGIN AND DEVELOPMENT OF THE NERVOUS SYSTEM. By Charles Manning Child. Chicago: The University of Chicago Press, 1921. 296 p.

INDIVIDUALITY IN ORGANISMS. By Charles Manning Child. Chicago: The University of Chicago Press, 1915. 213 p.

The principle of functional integration, or the hypothesis that the complex behavior and morphological pattern of an organism are determined by its interaction with its environment, has never met with much favor among biologists because of the lack of a definite and precise theory as to its possible actual operation. In these two little volumes from the University of Chicago Press, *Individuality in Organisms* and *The Origin and Development of the Nervous System*, Professor Child has furnished us such a theory richly supported by experimental evidence accumulated through many years of careful research. In the former, Professor Child has exposed and developed his general thesis, and in the latter he has sought to apply it in explaining a specific problem—that of the evolution of the nervous system. Professor Child has called his theory a "dynamic conception of the individual"—dynamic in opposition to the more prevalent preformistic and vitalistic theories—and has developed the thesis "that the foundation of unity and order in the organic individual is the transmission of dynamic change, 'stimulus', and 'excitation' from one point to another in protoplasm". This excitation is produced by the reaction of a specific protoplasm to the external world, the responses arising in the region of the protoplasm where there is highest metabolic (oxidated) rate and being gradually transmitted to those of lower metabolic activity. The responses of the protoplasm to external (and later internal) stimuli produce regions or zones of metabolic activity to which Child has given the name "physiological gradients". These physiological gradients represent at first purely *quantitative* reactions whose localization and direction may be controlled, as shown by actual experimental data obtained from work with the lower organisms, by modifying the intensity of a stimulus and thereby the metabolic activity of the protoplasm. The effect of the greater metabolic activity of any region in the protoplasm is to differentiate this region or gradient from the remaining mass of protoplasm, and herein lies the origin of the qualitative differentiation of the material of the organism, or what amounts to the same thing, its morphological pattern. The permanency of the physiological gradient established depends upon the duration and the intensity of the metabolic activity induced by the exciting stimuli. If this is so, by controlling and directing these, one ought to be able to modify the morphological development of the individual. This is what Professor Child actually has been able to show

by his own and others' researches in the field of experimental physiology and zoölogy.

Another characteristic of the nature of the physiological gradient is its influence upon the development of other gradients. The gradients of higher metabolic activity exercise a certain inhibition and control over the formation and range of gradients of lower metabolic levels such that a relation of dominance and subordination is established between the levels of high and low metabolic rate. According to the author, "dominance or control of one part over another in the organism is a matter of difference in metabolic rate, the region of higher rate being dominant".[1] The coördination of the activities of the organism, or its physiological individuality, is determined by the interrelation of the dominant gradients. Polarity, for example, is due to the dominance of a single axial gradient; radial symmetry to a series of gradients radiating from or toward the central zone, either the periphery or center being the region of highest metabolic activity. The nervous system in the higher organism is nothing but a continuation of the development "of the primary relation of dominance and subordination existing at the beginning of individuation between regions of high and those of low metabolic rate".[2] In brief, the nervous system and its integrative action is not some new or different mechanism in the development of the individuation of the organism, but simply an evolution of the primary integrative mechanisms of the lower organisms, and it is to the elaboration of this part of his thesis that Child has devoted his entire second volume.

Professor Child's important contribution to the subject should certainly have a wide influence on contemporary biological and psychological theory. If the main point of his thesis is correct—namely, that the physiological individuality of an organism is the result of the interrelation between living protoplasm and the external world—then, as he himself points out, the immutable germ-plasm theory of Weismann must be renounced. We ourselves have never understood why biologists have continued to swallow the germ-plasm theory and its arbitrary distinction between soma and germ, together with the categorical denial of the possibility of transmitted characters, in spite of the evidence produced against it by Von Nageli and Hertwig, and its only redemption for having side-tracked so many promising biologists into spending the most active years of their lives counting chromosomes is their contribution to our knowledge of cellular biology. If, furthermore, as Child has tried to show, "the organism is fundamentally a specific reaction system in which quantitative differences

1 *Individuality in Organisms*, page 37.
2 *Ibid.*, page 61.

initiate physiological individuation, development, and differentiation", we must agree with him that "nothing can be more certain than that it acts essentially as a unit in inheritance", and that "neither characters nor factors as distinct entities are inherited, but rather possibilities which are given in the physico-chemical constitution of the fundamental reaction system, but not necessarily localized in this or that part of it".[1]

Acceptance of this view will do much to offset the influence of some unsupported theories of eugenics such as that advanced by Davenport. The authority of the Cold Spring Harbor School has been much shaken on the statistical side by certain criticisms of Professor Karl Pearson.[2] Professor Child now furnishes an even stronger argument against them from the purely biological side.

Professor Child's contribution, however, is not merely negative, but abounds in many suggestions that will bear fruit both in psychology and sociology as well as in pure biology. To make any reference at all to them in the manner they deserve would prolong very much our review, but we might note in passing that White already has made use of the principle of functional integration as the basis of his new book, *Foundations of Psychiatry*.[3]

Both little volumes are well written, but *The Origin and Development of the Nervous System* will make difficult reading for the non-technical, though educated reader, owing to the rather considerable theoretical biological and physiological knowledge it presupposes. On the other hand, a copious bibliography is appended. We regret, however, to note that, like many American writers who have had training in Germany, Professor Child makes practically no reference to French literature. This is particularly regrettable in this case, as he has thereby omitted all reference to the monumental work on *Chronaxie* by Professor Louis Lapique and his pupils.

DAVID WECHSLER.

Bureau of Children's Guidance, New York City.

NUTRITION AND GROWTH IN CHILDREN. By William R. P. Emerson, M.D. New York: D. Appleton and Company, 1922. 342 p.

In the whirlwind of popular interest in nutrition—an interest quite surpassing anything ever exhibited in regard to any legitimate aspect of health work up to the present—this book will be welcome, for Dr. Emerson has had a good deal to do with arousing this popular

1 *Loc. cit.* page 202.

2 *Mendelism and the Problem of Mental Defect.* Cambridge: Cambridge University Press, 1914.

3 New York: Nervous and Mental Disease Publishing Company, 1921.

zeal for nutrition. We have heard of whole communities, even whole countries, obsessed with an interest in fake cures, but no other group of scientific men has made quite the stir that our nutrition experts have. A few years ago the dentists drew the country's attention to the danger of defective teeth and the benefit to be derived from mouth hygiene and dentistry. The result, as is well known, was a great change in the habits of a large portion of our population and a corresponding improvement in the state of health of those who learned to care for their teeth. In view of the usual lethargy in regard to health habits, it is most gratifying to see the real enthusiasm that has sprung up concerning nutrition.

The reason that any cult becomes popular is because it promises a good deal. Health cults become popular for the same reason—they promise a good deal of good health, presumably, as a general rule, in return for a small expenditure of time, money, and effort. Anything so fundamental as a complete physical examination and a general revision of living habits, even though it promised a good deal, could not become very popular at the present stage of civilization because it involves too much. The cure of malnutrition by feeding is a very simple project. Those who advocate it most warmly are usually those who have in mind an equally simple diagnosis of malnutrition—namely, that based upon a correlation of figures with regard to weight, height, and age, the findings at one time being considered clearly diagnostic in some cases, or more recently, with the more scientific, the figures of one year being compared with those of another. We certainly would not insist that no individuals are "malnourished" because they are underfed, or that weight-height-age figures never indicate "malnutrition". Nor do we say that because "malnutrition" is usually far more complicated a condition than a mere matter of weighing and feeding, it would never be wise to act on a partial diagnosis and correct at least some of the simpler and more obvious lacks. We do maintain, however, that malnourished children and underweight children are not necessarily the same children. We do maintain that the child who is underweight according to the tables is not necessarily malnourished. Dr. Emerson notes these facts in his book, although many of his followers appear to have lost sight of them in attempting to carry out similar plans for nutrition classes. It is not at all scientific to make a diagnosis of malnutrition on measurements, or to attempt to correct it by feeding merely. Yet this is what is being attempted in many cases as a result of a misplaced zeal for the nutrition class. Some charitably inclined individual will order a Fairbanks scale with a measuring rod and a few gallons of milk a day to be sent to the school in her neighborhood. The teacher

is expected, and often tries, to conduct a nutrition class on this basis. The first few chapters of Dr. Emerson's book should be read carefully by any layman who is moved to do anything of this sort. The diagnosis of malnutrition is always a medical matter. The term in itself means nothing unless backed up by a complete physical examination. Least of all does it mean a failure to correspond to the weight tables. If malnutrition were to be diagnosed by laymen, if it were to be the one medical diagnosis that could be safely made by the untrained, it would be far more acceptable to the reviewer to have the basis for this lay diagnosis a mere inspection of the child rather than a mere weighing of him. Probably more teachers and nurses and social workers could arrive at a correct conclusion by looking at the child and comparing him with well children than by weighing him and comparing his weight with the tables.

Dr. Emerson's book will be of very great value to those who are conducting legitimate nutrition classes in which the diagnosis of malnutrition is scientifically made and the treatment of malnutrition is scientifically conducted by all other available means as well as by feeding.

FLORENCE MEREDITH.

Woman's Medical College of Pennsylvania.

AN ESSAY ON THE PHYSIOLOGY OF MIND. By Francis X. Dercum, M.D., Ph.D. Philadelphia: W. B. Saunders Company, 1922. 150 p.

This essay on the physiology of the mind is clear in thought and word. It goes straight to its mark, which is a physical explanation of mind.

Dr. Dercum joins Dr. Paton in a call for an unemotional study of human behavior and in a conviction that man is not so different from other living things as he prides himself on being, but he centers his attention upon "selective action" as seen in the amœba, the white blood cell, and in the synaptic nervous system. At the synapse, the junction between one neurone and another, chemical or other attraction may result in one neurone's being pulled closer to or farther away from another, thus facilitating or retarding the jump of the nerve impulse. Similar attraction may bring the first neurone at times to a third or fourth instead of a second neurone. Now, whether this result be produced by amœboid motion of the nerve cell or the glia cell or by changing "surfaces of separation", we have a mechanism capable of vast numbers of responses and a physio-chemical explanation of memory, of sleep and dreams, of psychoses, and of consciousness.

Memory depends upon the "facility among the neurones for reforming old combinations". Sleep is the discontinuance of the synaptic approach of axon to dendrite. If in sleep, with its generally widened synapses, a toxin is produced in the blood that facilitates the discharge of nervous impulses across some of the gaps and then impacts are received from the viscera, a field of cortical activity may arise that is protected from the correcting influence of the impulses coming in over the pathways of special sense, and we have dreams. When the synaptic gaps are locally widened, we may find, according to circumstances, a hysterical paralysis of one arm or, what is much the same thing, a system of ideas that cannot be brought into contact with the correcting influence of the impressions continually being received from the outside world. In melancholia, the usual resistance offered by the synapse is increased and in mania it is lessened. In dementia praecox we have relations between neurones which occur so often that the response is fixed and the synapse has lost its ability to respond in more than one way.

And finally, as to consciousness, it is present "only in those responses which are tended by a changing and actively varying relationship among the neurones". "Consciousness is itself a phenomenon of cortical transmission", and the past is represented always by the first and the future by the second neurone. Each impact upon a neurone releases energy that spreads in the line of least resistance of the most frequently traveled paths, but probably always involves some transmission laterally and up and down as well as straight ahead. But consciousness also includes the side and indistinct fields.

An essay dealing with such subjects must be severely held to its main course, and this Dr. Dercum has courageously done. It is both a pleasure and a discipline to follow his argument. He has consistently avoided any discussion either of faith or purpose, but some philosopher who wishes to discuss them may find in this essay a firm foundation of observed facts.

EARL D. BOND.

Pennsylvania Hospital for Mental Disease.

PSYCHOLOGY AND MENTAL HYGIENE FOR NURSES. By Mary B. Eyre, R.N. New York: The Macmillan Company, 1922. 200 p.

This little volume has at least the virtue of brevity, and an astonishing amount of material is covered. The style is simple and terse, almost definitional; paragraphs are short and headlined; there is a summary for each chapter.

The first half of the book gives a primer outline of general psychology according to the old-fashioned "faculty" conception. Forced

and often unwarranted attempts are made to establish an organic basis for mental activity. The second half begins with a more general philosophical discussion, sketchy in character, of the forces operative in the human personality. There follows an epitome of the more common neurological conditions and psychoneurotic reactions, the latter dealt with purely on the descriptive level. Child psychology is given superficial consideration. A chapter deals with the Binet-Simon intelligence tests. Throughout the work practical lessons are drawn for the nurse in regard to her own and her patients' mental attitudes.

Modern dynamic psychology of the Freudian type is touched upon daintily from time to time, but in a way to give no more than verbal orientation to the novitiate. A striking defect is the omission of any bibliography to guide the reader who may wish to pursue further some of the subjects considered in the text.

The book was evidently written for those with little background for the development of psychological knowledge. As a source from which to cram for a formal examination for nurses it is quite ideal. It falls far short of filling the real need for something that shall put the nurse in touch with modern points of view on human behavior and psychopathology.

MARTIN W. PECK.

Boston Psychopathic Hospital.

WHITTIER SOCIAL CASE HISTORY MANUAL. By J. Harold Williams, Willis W. Clark, Mildred S. Covert, and Edythe K. Bryant. Whittier: California Bureau of Juvenile Research (Bulletin No. 10), 1921. 98 p.

The purpose of this volume, one of a series issued at the California State School for Boys, is given in the introductory note, in which we are told that the aim is to describe the methods used in the Bureau of Juvenile Research, that the monograph may serve as a guide in the training courses for its own social workers and also as a means of informing others of the work carried on by the bureau. It is primarily, as its title indicates, a manual, comprehensive in scope and offering, besides, a bibliography, so that the interested reader may study further along any of the numerous lines that touch upon social case-work. The method outlined is more applicable for institutions and, it would seem, could be carried out only where there is either a very large staff or where the number of individuals studied is comparatively small.

Directions for the more mechanical aspects of the work—such as

recording, use of charts, order of arrangements, and the like—are very specific. This can hardly be said of the sections on such topics as family history, which, although they give information gathered concerning even remotely distant relatives, offer very little definite suggestion as to the specific qualities for which one is to inquire.

It is evident that the work of this research bureau is exceedingly thorough. Many sources are canvassed and a vast amount of data is gathered. To the reviewer it does not seem altogether clear that, once gathered, this data is focused upon the problem of delinquency. Much of it, surely, is not relevant in relation to the actual problem that the individual presents, although it should furnish ultimately remarkably fine material for scientific investigation of subjects biological, psychological, and sociological. It is stated that the goal is to answer the question: What should be done for the propositus? But one hardly sees the relationship of many of the facts to this question; nor do there seem to be always specific recommendations for the treatment of the individual, if we may judge from the case studies cited.

The illustrative case histories included show clearly the industry and thoroughness of the staff. It is not often that facts are obtained concerning five generations and ninety-seven individuals, all to answer the problem of one defective lad. It seems altogether too bad that out of this case material so little should bear upon the problem of delinquency *per se*.

In the light of the intensive study of the individual from so many sources, the final discussion of the case is altogether inadequate and one might readily take issue with the interpretations made, especially concerning "the probable cause of delinquency". In no one of the three cases given did the reviewer agree.

But whatever one may feel about the details, many of which are after all only incidental to the problem of the volume as a whole, commendation and admiration are once more due to the progressive spirit of the Whittier State School and the laudable desire of the research department to standardize its work and perfect its methods.

AUGUSTA F. BRONNER.

Judge Baker Foundation.

THE HEALTHY CHILD FROM TWO TO SEVEN. By Francis Hamilton Maccarthy, M.D. New York: The Macmillan Company, 1922. 235 p.

A book from this firm, with this title, would be likely to attract some attention, especially at a time when the conservation of a normal state of health is becoming more interesting than the correction of

the results of disease. An adequate book on this subject is much needed. Whether or not the parent who desires to do the best for his child will find quite all that he needs in this book, he will surely admire Dr. Maccarthy's ideals. "A city", he says, "is no place for real living. Rents are so high that only large incomes can command an apartment or a house worthy to be called a home." This statement near the beginning of the book would be likely to cause a necessarily urban parent to lose interest at once. "In the country there is space, less confusion, and greater safety. Less supervision is needed where are large yards, fields, and trees." It is hardly possible to disagree with the writer at such points. We agree with him when he says, "Now if ever is the time for life in God's out of doors, plenty of wholesome food, careful training, and long nights of refreshing sleep." We would agree with him also if he had merely said that healthful conditions and good care are what the child needs from two to seven, but we would hardly have felt that the reiteration of such truisms would constitute scientific grounds for a book for anxious parents.

It is plain that Dr. Maccarthy is a parent. He speaks with considerable affect in places. "There is no doubt that mothers and fathers sacrifice much for their children, and because of the little folks in their own home, feel tenderly toward all children." This tenderness, he goes on to say, in a not very original manner, is not enough. "As parents, we must not only adore our children; we must love them wisely." A general tone of adoring parenthood and happy home life pervades the book. "Given a homelike living room in which is a good-sized fireplace, what wonderful possibilities it holds for family gatherings in front of its friendly light and warmth! What a jolly place it is for the telling of bedtime stories, for popping corn and family counsel!" The chapters on training and education and on nerves and the mind would be of value in a distinctly elementary way if any parents could be found to whom the information and suggestions contained in them were not already an old story. Undoubtedly Dr. Maccarthy has found that there are parents in whom it is not safe to take anything whatever for granted.

FLORENCE MEREDITH.

Woman's Medical College of Pennsylvania.

PENOLOGY IN THE UNITED STATES. By Louis N. Robinson, Ph.D. Philadelphia: The John C. Winston Company, 1921. 344 p.

This work may be considered a concise and excellent history and review of most of the material published prior to 1920. It gives a systematic presentation of the many phases of the subject, and for

this reason is of value to the student or one entirely ignorant of the methods employed in the treatment of the offender. Fortunately, it is entirely devoid of sentimental twaddle.

The author concedes that we have not solved the criminal problem and that we know very little about criminals. He suggests that it may be well to place correctional institutions under the management, or at least under the supervision, of the educational department of the state. He wisely accepts the rapidly spreading idea that we must cease to consider our penal institutions merely as places of detention, but must go further and develop them as laboratories for the individual study, treatment, and training of the prisoner.

Very interesting is his presentation of the controversy between the advocates of the Pennsylvania plan and the so-called Auburn plan. Although this controversy took place many years ago, it still has definite relation to present-day problems in the administration of our penal institutions.

On the subjects of probation and parole, the author is well qualified to speak since he has been actively identified with those phases of the work for many years. It is stated that in 1920 one hundred thousand offenders were placed on probation, and that there were during that period only two thousand probation officers under appointment. This deplorable lack of probation officers—and the same thing is practically true as it relates to parole work—prevents the functioning of the system to anything like the maximum of its potentialities.

Considerable space is given to a discussion of the extremely important subject of prison labor. It is evident that the author has given careful thought to the subject, and while his conclusions may not be to the satisfaction of all those directly or indirectly acquainted with the difficulties involved, it must be admitted that his round-up of the various phases of the problem is of value.

With regard to capital punishment, he presents with fairness the arguments for and against, but his final conclusion indicates that he is decidedly averse to the use of the death penalty.

In the closing chapter his enumeration of next steps is to be commended. These include the socialization of our criminal courts, the further development of probation, the establishment of institutions for special types of offenders, the elimination of county and municipal jails as places of detention for sentenced prisoners, the abolition of the death penalty, the facilitation of transfer from one institution to another, and the making the development of character the goal of prison administration.

E. R. Cass.

American Prison Association.

THE EMOTIONS. By Carl Georg Lange and William James. Psychology Classics Reprint, edited by Knight Dunlap. Baltimore: Williams and Wilkins Company, 1922. 135 p.

A very happy choice was made by the editors of the new Psychology Classics series when they selected for their first volume the original articles by James and Lange on the emotions. Until now the original article by James, which startled the complacent philosophical psychologists and which pointed the way for recent investigations, lay buried in one of the volumes of *Mind*, published in 1884.

Although the fires of the original controversy have for the most part died down, the fruits of the victory are coming to light more and more every day. There has been, perhaps, no issue more decisive in permanently breaking psychology away from the apron strings of philosophy than the physiological and behavioristic interpretation of the emotions as against the philosophical theories of the "affections of the soul". Since the publication of Darwin's *Expression of Emotions in Man and Animals*, the progress toward scientific and experimental treatment of the emotions has been rapid. Darwin was particularly interested in the facial expression during emotions of various kinds, and the outward similarity of emotional expressions with those of extreme fatigue and exhaustion. Philosophy was still closely bound up with science, however, for we find him giving a teleological explanation as the cause of the various outward manifestations of the emotions. James is not so interested in explaining as in describing, and proceeds further than Darwin by making more extensive observations—the emphasis shifts from the description of the voluntary striated musculature that is involved to the involuntary and visceral system. He hints at a great complexity and "subtlety". "Hardly a sensation comes to us without sending waves of alternate constriction and dilatation down the arteries of our arms. The blood vessels of the abdomen act reciprocally with those of the more outward parts. The bladder and bowels, the glands of the mouth, throat, and skin, and the liver, are known to be affected gravely in certain severe emotions, and are unquestionably affected transiently when the emotions are of a lighter sort" (page 15). Here is an anticipation of the work done by Cannon and others.

Throughout the article, which is written in the usual delightful James style, one feels the verve of the propagandist who knows that he has much opinion against him and that his statements will be considered radical. It is this that makes the article alive and full of interest to us to-day. When we unsuspectingly come upon this well-known sentence: "If we fancy some strong emotion and try to

abstract from our consciousness of it all feelings of its characteristic bodily symptoms, we find we have nothing left behind, no 'mind-stuff' out of which the emotion can be constituted, and that a cold and neutral state of intellectual perception is all that remains", we recognize it as a sword, even though now it has been turned into a plowshare.

It is interesting to note that in making practical application to everyday life from his theory, James arrives at a set of rules quite different from some of the more modern psychologists. If an emotion is repressed, it will disappear, according to James—"when we teach children to repress their emotions, it is not that they may *feel* more—quite the reverse. It is that they may *think* more, for to a certain extent whatever nerve currents are diverted from the regions below must swell the activity of the thought tracts of the brain." Perhaps here is a chance for another controversy!

In publishing the article by Carl Georg Lange, the editors have performed a double service, for they have given us the first English translation of the original article by Lange, and have placed it alongside of the James article for comparison. Although the theory has frequently been called the "James-Lang theory", each author developed his theory independently, nor are they identical. Lange speaks of the "involuntary physical manifestations which go hand in hand with the subjective feelings of fear, joy, etc." James does not differentiate, but calls these bodily manifestations the emotions themselves. Lange, however, gives a much more detailed analysis of the emotions, describing the four principal emotions—sorrow, joy, fright, and anger—in physiological terms, fright being accompanied "by paralysis of voluntary musculature and a kind of convulsive condition of the vascular musculature". He suggests that the best method of studying the emotions is the observation of animals and infants—methods that have been used by some of our contemporary psychologists. Like James, Lange was convinced that the notion of the emotions popular at that time was a putting of the cart before the horse, and that in discussing the "influence of the affections upon the body", Aristotle was looking at the problem from the reverse side. Lange practically reduced all the causes of emotional disturbances to disturbances in vasomotor innervation. The article is distinctly modern in tone and the translation by Miss Istar A. Haupt brings out the argument very clearly.

The third article is a reprint from James' *Principles of Psychology*, Chapter XXV—the well-known chapter on emotions. Here the style is more controversial than in the first article. James reviews Lange's

contribution, takes issue with him on various points, and answers the objections that were raised to his own theory after its original publication in *Mind*.

It is certainly very convenient to have these three papers reprinted and bound together in a small, easily handled volume. It will be welcomed especially by those who are teaching psychology, for it will save time and serve as a ready reference book.

SADIE MYERS SHELLOW.

Smith College.

A PSYCHIATRIC MILESTONE. BLOOMINGDALE HOSPITAL CENTENARY, 1821–1921. Printed privately by the Society of the New York Hospital, 1921. 220 p.

On May 26, 1921, the Bloomingdale Hospital celebrated its centenary. The principal place in the celebration was given to the sociologic and medical aspects of the work of the hospital, with special reference to the progress that had been made in the direction of the practical usefulness of psychiatry in the treatment of illness generally and in the management of problems of human behavior and welfare. In this beautifully printed volume, the governors of the New York Hospital have preserved the valuable addresses that were made on that occasion—*An Historical Review,* by Edward W. Sheldon, President of the Society of the New York Hospital; *The Contributions of Psychiatry to the Understanding of Life Problems,* Dr. Adolf Meyer; *The Importance of Psychiatry in General Medicine,* Dr. Lewellys F. Barker; *The Biological Significance of Mental Illness,* Dr. Richard G. Rows, Director of the Section on Mental Illnesses of the Special Neurological Hospital, Tooting, London, England; *The Relation of the Neuroses to the Psychoses,* Dr. Pierre Janet, Professor of Psychology, College de France; *The Medical Development of the Bloomingdale Hospital,* Dr. William F. Russell.

In the appendices have been preserved a number of historical documents of importance, including a letter on pauper lunatic asylums from Samuel Tuke to Thomas Eddy, 1815, and Thomas Eddy's communication to the Board of Governors, April, 1815. It was this communication that led eventually to the establishment of Bloomingdale Hospital in 1821 on the site now occupied by the library of Columbia University. The hospital was moved to its present location in White Plains in 1892, and the original site is now occupied by Columbia University, Barnard College, the Cathedral of St. John the Divine, St. Luke's Hospital, the Women's Hospital, and The National Academy of Design.

Valuable photographs have likewise been preserved in the volume—New York Hospital and Lunatic Asylum, 1808; Bloomingdale Asylum, 1821, 1894, 1921; the tableau pageant given at the centenary; and an autograph photograph of Thomas Eddy.

THE SOCIETY OF THE NEW YORK HOSPITAL, 1771–1921. COMMEMORATIVE EXERCISES, 150TH ANNIVERSARY. Privately printed, 1921. 96 p.

A beautifully printed record of the addresses made at the exercises held in Trinity Church, New York City, October 26, 1921, to commemorate the 150th anniversary of the granting of a charter to the New York Hospital. The more significant addresses are by Edward W. Sheldon, President of the Society of the New York Hospital; Nathan L. Miller, Governor of the State of New York; and the Honorable Elihu Root. Mr. Sheldon's address is a valuable historical sketch of the work of the hospital and of the early medical activities in New York City.

Governor Miller stresses the importance of the work being done at the Bloomingdale Hospital (the department of the New York Hospital devoted to the treatment of nervous and mental diseases) particularly in the demonstration of the value of occupational therapy. He feels that the state should profit by this experience and that more intensive work along this line should be undertaken by the state hospitals. Mr. Root points out that in this country we "depend upon individual enterprise for our motive power" rather than upon the government, and characterizes the hospital as an example of the "free and independent enterprise of our people". With feeling he calls attention to how lives are built into institutions: "The men who originated and have maintained the New York Hospital have had civic pride and the most generous of hearts. I myself have known in close friendship many of the men who were long ago giving their time and their labor and their enthusiasm and their loyalty to this institution. There are but few, I fear, who remember them now; but it seems to me that in this celebration that I am taking part in, I am saying something in honor of Cornelius Bliss and Lewis Stimson, and the others who gave so much of their lives in this work. Their names will not be long remembered; their predecessors' names are already forgotten. But what matters that? They have built their lives into this institution. Their spirits live in the spirit of this institution, and make it always strong, wholesome, and effective. Theirs is no human fame that endures for very long. What if their names are forgotten? They are here, they live here, their influence continues here, and the things that they have

done still live in this institution, and in a few other institutions of a similar spirit."

Several photographs of historic interest are included in the volume, among them a view of the New York Hospital, 1808; the approach to the hospital, 1851; and Bloomingdale Asylum in 1881, New York City (the site of the present Columbia University Library).

SELF-MASTERY THROUGH CONSCIOUS AUTO-SUGGESTION. By Émile Coué. New York: American Library Service, 1922. 93 p.

This book has been advertised so extensively that it is probably well to say something about it, although ordinarily it would receive no space. So far as auto-suggestion and the views of Coué are concerned, they need not be discussed in connection with this book as they have already been discussed in MENTAL HYGIENE in a review of Baudouin's *Suggestion and Auto-suggestion*.[1] It is necessary only to point out the type of book this particular book is; comment is superfluous.

The book is a fair-sized paper-covered pamphlet of ninety-three small pages (approximately one-half the size of the MENTAL HYGIENE page cut horizontally), badly printed on inexpensive paper. It is advertised to sell for one dollar ("postpaid, bound in genuine flexible leather, $1.75"). It is not written by Coué, as one is led to believe. An article occupying the first thirty of the ninety-three pages is signed by him; the last five, on *Education As It Ought To Be*—in which he says, "in sober truth, if a woman, a few weeks after conception, make a mental picture of the sex of the child . . . of the physical and moral qualities . . . the child will have the sex and qualities desired"—are also by him. Six pages are devoted to *Thoughts*, etc., by Coué, although the last two pages are by others—such as *Suggestion Sustained by Faith Is a Formidable Thing*, signed "Docteur A. L., Paris (July, 1920)"—and seven pages to *Observations*—brief statements to the effect that "T— Maurice, aged 8 and and a half" has been cured of a club foot and Mme. M— and Mme. D— of prolapse of the uterus, and the like.

Seventeen of the ninety-three pages are devoted to testimonial letters of the old patent-medicine type and five more pages to a *Homage*. The remaining pages of the pamphlet are given to odds and ends of a like character. A form of application for membership in the "Lorraine Society of Applied Psychology—Suggestion, Auto-suggestion, Hypnotism" concludes the book except for the precepts on how to use auto-suggestion on the inside of the front cover. As has been said, the price asked for this book is one dollar.

[1] October, 1921, Vol. 5, pp. 856–7.

THE DEPTHS OF THE SOUL: PSYCHOANALYTICAL STUDIES. By William Stekel. Translated by S. A. Tannenbaum. New York: Moffat, Yard, and Company, 1922. 216 p.

Stekel has written books that are to be read (his *Bisexual Love*, for example), but this is not one of them. To the book he has given an absurdly pretentious title, but to the text—short discourses on obviously popular themes, *Jealousy, Gratitude, Independence, Moody People*, etc.—he has given little but aphorisms and an attempt at a literary *flair*. The depths of the soul are not to be sounded or knowledge of importance disseminated in superficial books such as this.

THE PSYCHIC HEALTH OF JESUS. By Walter E. Bundy, Ph.D. New York: The Macmillan Company, 1922. 299 p.

A careful and critical review of the work of those who—from Strauss and Renan to Binet-Sanglé—have pronounced Jesus of unsound mind. Chapters are also given to a discussion of source material and of the personality of Jesus from the pathographic point of view. The author points out that psychiatric diagnoses cannot safely be based on biographical or autobiographical material alone and that in the case of Jesus the material is entirely inadequate. He concludes that Jesus was not an ecstatic (Holtzmann), an epileptic (Rasmussen), or a paranoiac (De Loosten, Hirsch, Binet-Sanglé) and that although "his picture of the future, and that of many of his contemporaries, was fantastic and fanciful, it was not fanatical". The term psychoanalysis is used frequently throughout the book, but evidently in its etymological and not in the technical sense. There is an excellent bibliography. The author is Associate Professor of the English Bible at DePauw University.

THE TECHNIQUE OF PSYCHOANALYSIS. By David Forsyth, M.D., D.Sc., F.R.C.P. New York: Moffat, Yard, and Company, 1922. 133 p.

The technique of psychoanalysis cannot be taught in a small book. However, presupposing a considerable knowledge of the subject on the part of the reader, as the author does, the book will be found helpful by physicians undertaking the study of psychoanalysis. The major portion of it is given to a discussion of the analysis proper, but there is an important chapter on the analyst himself and one on the prerequisites of treatment.

NOTES AND COMMENTS

Illinois

A new building has been opened at the Elgin State Hospital to be devoted exclusively to ex-service men. The construction of this building was begun in June, 1921, and it was completed the following May. It is a one-story building comprising three distinct units. It contains a dining-room that seats 175 persons. It has two main wards and four smaller wards.

Kentucky

The Kentucky Child Welfare Commission has been created by Chapter 107, Laws of 1922. This commission is to be composed of nine members appointed by the governor, three for a period of one year, three for two years, and three for three years. It shall be the duty of the commission to continue the survey of child welfare begun by the children's code commission authorized in 1920, to study the needs of Kentucky children, to present to the governor and legislature prior to each session a report of their findings and recommendations, and to be ready at all times to advise the governor or any member of the legislature concerning the bills relating to children that may be introduced at any session.

Louisiana

The State Colony and Training School received from the 1922 legislature an appropriation of $266,000 for the next biennial period. Of this amount, $155,000 is to be expended for new buildings and $25,000 for a power and heating plant. This institution was authorized by the 1918 legislature as a state institution for the feebleminded and was opened in December, 1921.

The law relating to admission to the State Colony and Training School has been amended by Act 27, Laws of 1922. The new law allows admission to this institution without court procedure, in accordance with the following section: "On application for admission to a hospital made on behalf of a person who is a resident of the state, the superintendent and board of administrators may admit him to the same, although he had never been adjudged feebleminded. Upon receipt of the application, the superintendent must forward to the physicians proper blank forms to be filled out, giving the history of the patient and such other information as may be required. The

admission, discharge, and parole of such voluntary admission are left to the discretion of the board of administrators."

The name of the state hospital for mental diseases located at Jackson has been changed by legislative enactment from "The East Louisiana Hospital for the Insane" to "The East Louisiana State Hospital".

Massachusetts

A new parole law for mental defectives was enacted by the 1922 legislature. It permits the trustees of any state school for the feebleminded to allow any inmate to leave the institution on parole for such length of time and under such conditions as they may determine. The length of time may be extended and the conditions changed from time to time. Before granting a parole to any person, the trustees must have an investigation made of the home and other conditions that may affect his welfare, and must provide such supervision as they deem necessary. The trustees have power to revoke the permit and to return the patient to the school.

Missouri

Work is starting on a new building at State Hospital No. 2 at St. Joseph. The building will be devoted to surgery, with operating, dental, X-ray, and laboratory rooms. It will accommodate 42 patients and cost about $100,000.

New Jersey

Chapter 101, Laws of 1922, provides for the commitment to the house of detention for criminal insane at the State Hospital at Trenton of persons who have been sentenced to death and are found to be insane. When such a person is sufficiently improved to understand that he has committed the crime for which he was convicted, is aware that he is amenable to punishment therefor, and is appreciative of his situation as one condemned to death, he shall be returned to the state prison and subsequently resentenced. When any person shall have escaped indictment or have been acquitted upon the ground of insanity, he shall be committed to the State Hospital at Trenton until his reason is restored, but such person shall not be released except upon order of the trial justice having jurisdiction to try such person.

New York

A new mental-hygiene clinic has been established in Batavia by the Rochester State Hospital.

Mrs. Eleanor Clarke Slagle has been appointed by the state hospital commission director of occupational therapy in the state hospitals.

The following new buildings for the Utica State Hospital have been authorized: a nurses' home, a dormitory for 300 patients, and a building to accommodate 125 working patients.

Rhode Island

A law enacted by the 1922 legislature allows the transfer of patients who have been committed to the state hospital for mental diseases or Butler Hospital to a hospital under the control of the United States Government, whenever it shall be deemed by the superintendent of either of the former hospitals to be for the welfare of the patient to be thus transferred.

Chapter 2230, Laws of 1922, which is in amendment of and in addition to a law enacted in 1917 creating the penal and charitable commission, provides for a director of state institutions as the chief executive officer of the commission. One provision of the new law is of especial interest in that it authorizes the commission to appoint a resident physician and two assistant physicians for the institutions under its control at Cranston, one of whom must be a psychiatrist. The institutions thus affected are the state prison, the state workhouse and house of correction, the state school for boys, the state school for girls, and the state infirmary.

South Carolina

A law passed by the 1922 legislature states that the regular discharge of a patient from the state hospital for mental diseases shall restore to him his legal status as to property and contractual rights, provided that any patient of that hospital duly adjudged insane in any probate county of the state obtain from the superintendent of the state hospital a certificate showing that the patient has been adjudged sane by the medical staff of the hospital.

Virginia

A law enacted by the 1922 legislature authorizes that occupational therapy, with part-time or full-time services of one or more occupational aids, be provided in institutions caring for children who are either physically or mentally disabled.

A 1922 amendment to the law relating to the adoption of minor children authorizes the court, upon the filing of the petition, to direct a probation officer or other officer of the court, or an agent of the state or county or city board of welfare, or some other discreet and competent person, to make a thorough investigation, directing his

inquiry along the following lines: (1) why the parents, if living, wish to be relieved of the care of the child; (2) whether they have abandoned the child or are morally unfit to have its custody; (3) whether the proposed foster parent or parents is or are financially able and morally fit to have the care of the child; and (4) the physical and mental condition of the child. For this latter purpose the investigator may secure the opinion of a reputable physician or competent mental examiner.

The board of charities and corrections is to be continued under the name of state board of public welfare in accordance with Chapter 105, Laws of 1922. The board is to appoint a commissioner of public welfare as its executive officer, and it may also appoint an assistant commissioner of public welfare. All other assistants and employees attached to the board are to be appointed by the commissioner. The members of the board, five in number, are to be appointed by the governor, subject to confirmation by the senate. The duties of the new board are practically the same as those of the former board, but the following new provision is worthy of special mention:

"The board is hereby authorized and empowered to create a children's bureau, and if such bureau be created, the commissioner of public welfare may, subject to the approval of the board, appoint a director of the bureau and such assistants as may be necessary. The children's bureau, subject to the control of the board, shall have general supervision of the interests and welfare of the mentally defective, dependent, delinquent, and neglected children of Virginia; shall investigate conditions bearing upon this subject, and shall from time to time recommend to the board of public welfare and to public and private agencies, measures, curative and remedial and preventive or constructive, for the improvement of conditions and the better safeguarding the welfare of the children of the state. The board is hereby authorized and empowered to receive mentally defective, delinquent, dependent, and neglected children committed to it by courts or justices, and all children declared by any court or justice to be delinquent and not suitable for probation shall be committed to the state board of public welfare, which board is authorized to establish one or more receiving homes for the care, supervision, and study of mentally defective, delinquent, dependent, or neglected children thus committed to it, or to make arrangements with satisfactory persons, institutions, or agencies, or with cities maintaining places of detention for children, for the temporary care of its wards. The board is further authorized to make a careful physical and mental examination of every such child, to investigate in detail the personal and family history of the child and its environment, and to place children in approved family homes, in suitable licensed institutions, all within the state of Virginia, unless by written consent of its parent or guardian, with suitable licensed agencies, or in state institutions. Children committed to state institutions dealing exclusively with children, by the board, shall take precedence as to admission over all others and shall in all cases be received into the said state institution as soon as possible. Children placed in family homes or institutions may be transferred for reasons deemed sufficient by the board."

An examination for venereal disease is required by Chapter 315, Laws of 1922, of all persons admitted to the state penitentiary, state penitentiary farm, any branch prison, any reformatory, any hospital for insane or colony for epileptic and feebleminded. Any such person found to have a venereal disease must be treated and, if possible, cured.

When a dependent, neglected, or delinquent child is brought before a court in the state, the court may either before or after the hearing cause the child to be given a physical and mental examination by a competent physician or physicians or an approved mental examiner. If it shall appear to the court that the child is mentally defective, he must be examined by two licensed physicians or approved mental examiners, and upon their written statement that the child is mentally defective, the court may commit the child to an institution for mentally defective children. Parents, guardians, and custodians must be given due notice of the proceedings. When the health or physical condition of a child requires it, the court may cause the child to be treated by a competent physician or placed in a public hospital or institution for treatment. These provisions are included in Chapter 481, Laws of 1922, of Virginia.

Mental Hygiene Survey of Cincinnati

The Mental Hygiene Council of the Public Health Federation of Cincinnati has issued in pamphlet form a short summary of the report on the survey of Hamilton County, Ohio, conducted by The National Committee for Mental Hygiene, at the request of the Mental Hygiene Council, during the year 1921–22. The survey was directed by Dr. V. V. Anderson of the National Committee. Its aim was to determine the part played by abnormal mental conditions—feeble-mindedness, psychopathic states, epilepsy, and the like—in the various social problems of the city and county, particularly dependency, chronic unemployment, illegitimacy, family desertion, vagrancy, juvenile delinquency, and adult crime, and to ascertain the frequency of mental abnormalities among the public-school children. The material investigated included the "run of the mine" of the cases under the care of the Ohio Humane Society, the Associated Charities, and the Bureau of Catholic Charities, fifty dependent families under the care of the United Jewish Social Agencies, the "run of the mine" of the juvenile court, the opportunity farms for boys and girls, the Hamilton County Jail, the city and county infirmaries, the Home for the Friendless, the Catherine Booth Home, the boarding-homes children, and finally about 5,000 public-school children. The object was to secure a thorough-going physical, mental, and social diagnosis of each

individual studied. Both psychiatric and psychological methods were used in the mental examination, which was directed, first, to determining the presence or absence of mental disease in the individual in question; second, to evaluating his intelligence; and third, to estimating his character and personality make-up. The social investigation included a study of home conditions in all cases except those of public-school children who were not found to be suffering from any abnormal mental condition.

The findings of the survey, as summarized in the pamphlet, are as follows:

Delinquency

Approximately two-thirds of the children studied at the juvenile court were found to be suffering from some form of mental abnormality—either psychopathic personality, epilepsy, feeblemindedness, border-line mental defect, mental disease, or subnormal intelligence. Nearly two-thirds of these children had intelligence quotients of over 80, which shows that marked inferiority in intelligence is not an outstanding causative factor in their delinquent conduct, but that the problem is primarily one of behavior difficulties or mental maladjustments. Approximately 7 out of every 10 children came from homes in which conditions in the way of parental control and parental supervision were at the lowest ebb, the homes of the girls being more unfavorable than those of the boys; 9 out of every 10 delinquent girls came from homes that received the lowest possible rating in respect to parental control and supervision. Twenty per cent of the mothers in the group of delinquent girls were sex delinquents. Forty per cent of the fathers of the psychopathic delinquent children were alcoholic, and 25 per cent were guilty of nonsupport or of desertion. Some idea of the cost of these socially maladjusted families can be gathered from the fact that 3 out of every 5 of them have come into contact with one or more of the social agencies of the city, in addition to the juvenile court.

Only 13 per cent of the girls at the Girls' Opportunity Farm were diagnosed as normal; 40 per cent were suffering from psychopathic personality, and 21 per cent from border-line mental defect or feeblemindedness. Of 68 boys examined at the Boys' Opportunity Farm, only 11 were found to be normal; 30 were suffering either from border-line mental defect or feeblemindedness, and 15 were diagnosed as psychopathic personality.

Of 100 cases, the "run of the mine", studied at the Ohio Humane Society, 66 per cent were suffering from some nervous or mental abnormality; 26 per cent were feebleminded, and 8 per cent mentally diseased.

Of 200 cases studied at the Hamilton County Jail, 74.5 per cent were classified as cases of mental disease, mental defect, psychopathic personality, epilepsy, psychoneurosis, or subnormal intelligence.

Of a group of 70 unmarried mothers, only 20 were classed as normal. There were 28 cases of border-line mental defect or feeblemindedness, 10 of subnormal intelligence, 7 of psychopathic personality, 3 of psychoneurosis, and 2 of epilepsy.

Fifty-one per cent of the adult delinquents were repeated offenders.

Dependency

Twelve hundred cases of dependency were studied.

In contrast to the group of delinquent children, of whom approximately two-thirds were suffering from some nervous or mental abnormality, it is noteworthy that more than two-thirds of the group of dependent children were classified as normal. The majority of the adult dependents, on the other hand, were mentally or physically sick or handicapped.

Of 61 adult dependents studied at the Bureau of Catholic Charities, 4 out of every 5 were found to be suffering from some abnormal mental condition.

Of 212 cases studied at the United Jewish Social Agencies, as part of a survey of 50 dependent Jewish families, 50 per cent were suffering either from mental disease, feeblemindedness, epilepsy, psychopathic personality, or endocrine disorders.

Of 122 relief cases, the "run of the mine", at the Associated Charities, approximately 72 per cent were classified as mentally abnormal.

Of a group of cases of chronic unemployment studied at the Associated Charities, 71 per cent were suffering either from endocrine disorders, epilepsy, mental deficiency, mental disease, or psychopathic personality, or were distinctly subnormal in intelligence.

Of 394 patients at the city infirmary, only 20.3 per cent of the whites were mentally normal; all the rest were either mentally sick or mentally crippled. Of the 39 negroes studied at this institution, only 3 were diagnosed as normal.

Of 162 cases at the Hamilton County Home, only 4.5 per cent of the white persons could be classed as mentally normal. All the negroes were either feebleminded or mentally diseased.

The Public Schools

The public-school children studied were the pupils of five typical schools in different parts of the city. The aim was to get a fair picture of the average child and to ascertain what proportion of the children were mentally handicapped or maladjusted.

It was found that 2 per cent of the children studied were feeble-minded; 2 per cent were cases of border-line mental defect; 3.5 per cent were diagnosed as nervous or psychopathic and 4.8 per cent as subnormal; 0.2 per cent were suffering from epilepsy and 0.7 per cent from endocrine disorders. It should be noted that the children suffering from the more gross mental defects had already been weeded out and placed in special classes by the public-school authorities, and were therefore not included in these percentages.

Approximately 6 per cent of the children studied showed marked conduct disorders. A great majority of these conduct cases were among the children suffering from mental handicaps.

The survey showed that the public schools of Cincinnati are particularly well equipped to deal with the problem of school children whose shortcomings are largely in the field of general intelligence, learning capacity, vocational aptitudes, and the like, but that the psychopathic children and the children with conduct disorders, who form such a large percentage of the city's public-school problems, are not being effectively dealt with; the conditions from which they suffer are not adequately recognized and given the medical and social treatment that they deserve.

Conclusions

The outstanding facts revealed by the survey are (1) the vital part played by psychiatric conditions in all the social problems the city has to meet and (2) the inadequacy of the facilities for dealing with these conditions. While splendid efforts are being made in various directions to meet the mental-hygiene needs of the city, in no place is the work sufficiently comprehensive or adequately enough financed to supply the service that the situation demands. Various organizations are doing excellent clinical work, but each piece of work is a separate unit, revolving on its own axis, absolutely independent of other activities. The urgent need is for a large central psychiatric clinic which would coördinate all the work of this kind that is being done in the city, serving the social agencies, the institutions for delinquents and dependents, the juvenile and adult courts, the public schools, and the community in general.

Emphasis is laid upon the fact that this central clinic should not be merely a classification clinic. It should be primarily a treatment clinic, which, through its social-service department, would coöperate with the trained workers of the city's social agencies, with the probation officers in the courts, and with the supervisors of the problem school children, to work out a program for the treatment of each individual brought to it for study.

The clinic should be a part of the clinical facilities of the General Hospital. Its director should be a full-time man, a physician with ample clinical experience who has specialized in psychiatry, with particular reference to the social phases of the problem. In addition to directing the clinic, he should be Professor of Social Psychiatry and Mental Hygiene at the University of Cincinnati, and give courses of lectures in the medical school and the law school and in connection with the training of school teachers and social workers.

A complete report of the survey, including a study of the feeble-minded in Hamilton County and a state program for mental hygiene, can be obtained from the Public Health Federation of Cincinnati, 25 East Ninth Street, Cincinnati, at the price of a dollar.

Mental Hygiene Activities in Pennsylvania

Recognizing the importance of occupational therapy in hospitals for mental disease, the Bureau of Mental Health of the Pennsylvania Department of Public Welfare, which went into operation last December under the directorship of Dr. William C. Sandy, has established the position of field representative in occupational therapy and appointed to the position Miss Mary L. Putnam, who has had extensive experience in the work in various states and institutions. Miss Putnam is now making a survey of occupational-therapy activities in the institutions of Pennsylvania and is also available for consultation. Several of the mental hospitals in Pennsylvania are doing excellent work in occupational therapy, and it is hoped that, through Miss Putnam's efforts, this work will be extended throughout the entire state.

In the interest of extramural activities, the department of public welfare has appointed Miss Florentine Hackbusch to the position of field representative of the bureau of mental health. Miss Hackbusch, who was formerly field agent of the New York State Commission for Mental Defectives, will assist in organizing and conducting mental-health clinics. The bureau is promoting the establishment of such clinics and expects in the near future to have one in operation in every section of the state.

Finding that there were several hundred beds available in the state hospitals, the bureau has revoked the licenses of a number of small county hospitals for mental disease and transferred their patients to the state hospitals. This has been done in five counties and similar arrangements are being made in three others.

The Danville State Hospital, as a part of its community-service activities, has instituted a course of lectures on abnormal psychology and mental hygiene at the state normal school at Bloomsburg.

Lectures were delivered to 140 senior students during the winter months, and the summer course was attended by 550 teachers, representing communities in all parts of the state. The lectures are supplemented by clinical demonstrations at the hospital.

Probably Manic-Depressive

Under the heading *Osteopathic Research*, the *Journal of the American Medical Association* quotes the following from the Dayton (Ohio) *Herald:*

"Dr. Burns, who is head of the A. T. Still Research Institute, spoke Tuesday night at a meeting of the Dayton District Osteopathic Society.

" 'We use three or four hundred rabbits, monkeys, guinea pigs, and similar animals each year', she said, Tuesday. 'We produce certain lesions, study their effects, and then either reduce the lesion or kill the animal as seems best for the purpose of the experiment. We are careful to cause the animal no pain.

" 'We were able to render one rabbit blind, by a lesion similar to the celebrated case of Tom Skaybill, whose sight was restored by one of our practitioners. We were unable to restore the rabbit's sight however, as it died of indigestion.

" 'We caused one rabbit to develop dementia praecox and held it under observation for three years. It lost all interest in life, ate very little, grew dirty and unkempt, and was generally worthless. We are now making the adjustment required and the rabbit is beginning to recover.

" 'As a result of our work, we have been able to discover causes of several ailments now marked "cause unknown" in standard medical works. Among them are certain forms of localized dropsy and paralysis.' "

Neuropsychiatric Number of the New York Medical Journal

The *New York Medical Journal and Medical Record* for September 6 was devoted to the subject of neuropsychiatry. Sir Frederick Mott, of London, and Dr. Miguel Prados Y Such, of Madrid, were the coauthors of the leading article, *Further Pathological Studies in Dementia Praecox, Especially in Relation to the Interstitial Cells of Leydig.* This paper, which was concluded in the next number of the *Journal*, described the appearance of the interstitial cells in various forms of mental disease and compared them with the normal at various ages and with one another, with special reference to dementia praecox. Dr. L. Pierce Clark contributed a study of the unconscious motivations in suicides, and Dr. Gregory Stragnell a paper entitled *Psychopatho-*

logical Disturbances from Avoidance of Parental Responsibility, based upon an analysis of the psychopathological problem involved in four recent plays—*Liliom, A Bill of Divorcement, Mary Rose,* and *Anna Christie.* Among the other articles of interest were *Folie à Deux,* by Dr. John H. W. Rhein; *Notes on a New Treatment for Mongolian Idiocy,* by Dr. William N. Berkeley; and *The Origin and Scope of the Modern State Hospital,* by Dr. Clarence A. Bonner.

The editorials include one on a recent article by William McDougall, *The Use and Abuse of Instincts in Social Psychology;* one on Freud's *Traum und Telepathie;* and a very sympathetic discussion of Nelson Antrim Crawford's *Mental Health and the Newspaper,* which appeared in the April number of MENTAL HYGIENE. The Wisconsin mental-deficiency survey and the relation between the sympathetic nervous system and the endocrine glands were other subjects discussed.

The book-review section was largely devoted to reviews of books in the field of neuropsychiatry.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

The annual meeting of the American Occupational Therapy Association was held at Atlantic City the last week in September. The association met in conjunction with the meeting of the American Hospital Association. There was an excellent program and probably the best exhibit of occupational-therapy work that has been held in this country. The following were elected officers for the coming year: President, T. B. Kidner, National Tuberculosis Association, New York City; Vice-president, Dr. G. Canby Robinson, Johns Hopkins Hospital, Baltimore; Secretary-Treasurer, Mrs. Eleanor Clarke Slagle, Director of Occupational Therapy, New York State Hospital Commission, Albany.

THE CALIFORNIA SOCIETY FOR MENTAL HYGIENE

During the past year the California Society for Mental Hygiene, under the leadership of its president, Dr. Harold Wright, has devoted itself to educational propaganda on the subject of the need for psychopathic wards in the San Francisco Hospital and other general hospitals. Meetings were held with the San Francisco Board of Health and the supervisors of the city and county, and in January a public meeting was called for full discussion of the subject, representatives of many civic organizations being invited to express their views. Publicity was obtained through one of the newspapers also. The San Francisco Hospital has the space for these psychopathic wards

and has had since it was built, but no appropriation for opening them has yet been made.

The society has also held meetings on the subjects of psychiatric clinics and the relation of crime to mental disease. Two lectures on mental conditions in childhood were given at the summer session of the California Teachers College, one by Dr. Wright and one by Dr. Eva C. Reid, and Dr. Wright gave a further course of lectures at Teachers College on feeblemindedness, psychopathic hospitals, early manifestations of mental disease, some aspects of psychoanalysis, and the psychiatric viewpoint on crime and delinquency.

During the coming winter the society plans to work for the amendment of the present insanity laws of California with the object of doing away with some of the cumbersome legal formalities attending admission to psychopathic hospitals, making them more easy of access for patients and their relatives.

A Postgraduate School of Neurology and Psychiatry

Under the title of the Postgraduate School of Neurology and Psychiatry of the District of Columbia, a school for the graduate teaching of diseases of the nervous system has been recently organized in Washington and opened formally in October. Dr. William A. White, Superintendent of St. Elizabeth's Hospital, is President of the institution; Dr. Tom A. Williams, Vice-president; Dr. Daniel D. V. Stuart, Jr., Secretary-Treasurer; and Dr. D. Percy Hickling, Dean of the Faculty. Two courses of study, elementary and advanced, of six weeks each are to be offered, together with an elective course in special subjects.

CURRENT BIBLIOGRAPHY*

JULY–SEPTEMBER 1922

Compiled by

DOROTHY E. MORRISON

The National Committee for Mental Hygiene

*This bibliography is uncritical and does not include articles or books of a technical or clinical nature.

Ball, C. R., M.D. Thyroid and its relationship to nervous and mental symptoms. Minnesota medicine, July 1922, v. 12, p. 423.

Baudouin, Charles. Studies in psychoanalysis; translated by Eden and Cedar Paul. Lond., Allen, 1922.

Bennett, T. J., M.D. Plea for establishment of state psychopathic hospital. Texas state journal of medicine, June 1922, v. 18, p. 73.

Bernstein, Charles, M.D. Microcephalic people sometimes called "pin-heads". Journal of heredity, Jan. 1922, v. 8, p. 30–39.

Bingham, A. T., M.D. Psychiatric work of the New York Probation and Protective Association. Mental hygiene, July 1922, v. 6, p. 539–74.

Blaisdell, R. E., M.D. What patients may safely be paroled. State hospital quarterly, May 1922, v. 7, p. 311–18.

Bond, E. D., M.D. Internal secretions and the home. Mental hygiene, July 1922, v. 6, p. 522–25.

Bowen, A. L. How to improve the care and treatment of the mentally ill. Modern hospital, June 1922, v. 18, p. 506–08.

Bowen, A. L. Medical service which a state hospital should provide. Modern hospital, Aug. 1922, v. 19, p. 116–18.

Boyle, Helen, M.D. Ideal clinic for the treatment of nervous and borderland cases. Royal society of medicine. Section on psychiatry. Proceedings, Aug. 1922, v. 15, p. 39–48.

Bridges, J. W. Value of intelligence tests in universities. School and society, March 18, 1922, v. 15, p. 295–303.

Briggs, L. V., M.D. Mental hygiene in its relation to present-day nursing. Modern hospital, Sept. 1922, v. 19, p. 236–40.

Brison, E. P., M.D. Training of subnormal children. Public health journal, Toronto, Aug. 1922, v. 13, p. 345–53.

Brooks, C. H. Practice of autosuggestion by the methods of Emile Coué, with a foreword by Emile Coué. N. Y., Dodd, 1922. 119 p.

Brown, F. E. Mental defect and venereal disease. Public health journal, Toronto, May 1922, v. 13, p. 222–29.

Brown, William, M.D. Suggestion and mental analysis. Lond., University of London press, 1922. 165 p.

Burnham, W. H. Newer aims of physical education and its psychophysical significance. American physical education review, Jan. 1922, v. 27, p. 1–7.

Burt, Cyril. Causes and treatment of juvenile delinquency. Psyche, 1922, v. 2, p. 339. (Cont.)

Buzzard, E. F., M.D. Some aspects of mental hygiene. Mental hygiene, July 1922, v. 6, p. 449–62.

Carothers, F. E. Psychological examinations of college students. N. Y., Columbia university press, 1922. 82 p.

Claude, Henri. Necessity for reform in the management and care of mental disease. Paris médical, May 27, 1922, v. 12, p. 433.

Cobb, M. E. Mentality of dependent children. Journal of delinquency, May 1922, v. 7, p. 132–40.

Cole, H. C., M.D. Some aspects of the mental hygiene of childhood. Public health journal, Toronto, April 1922, v. 13, p. 149–57.

Corey, C. E. Problem of the individual. Journal of abnormal psychology and social psychology, Dec. 1921–March 1922, v. 16, p. 374–83.

Courbon, Paul, M.D. Psychiatric import of a cathedral carving. Revue neurologique, Jan. 1922, v. 38, p. 52.

Craig, Sir Maurice, M.D. Nerve exhaustion. Lond., Churchill, 1922.

Culpin, Millais, M.D. Nomenclature of minor mental disorders. Journal of neurology and psychopathology, Aug. 1922, v. 3, p. 105–11.

Darwin, Leonard. National inheritance and social policy. Studies in mental inefficiency, July 15, 1922, v. 3, p. 49–55.

Diller, Theodore, M.D. Opportune appearance of mental symptoms in those accused of crime or facing crisis in life. West Virginia medical journal, May 1922, v. 16, p. 438.

Dodds, Samuel, M.D. Occupational treatment at Northern Indiana hospital for insane. Indiana bulletin of charities and correction, June 1922, p. 61–66.

Doll, E. A. Objective mental diagnosis. Journal of delinquency, May, 1922, v. 7, p. 119–31.

Dorbandt, Thomas, M.D. Our problem with the inadequate subnormal group. Practical medicine and surgery, May 1922, v. 37, p. 453–55.

Eager, Richard, M.D. Hints to probationer nurses in mental hospitals. Lond., Lewis, 1922. 80 p.

Ely, F. A., M.D. Mental standardization. Iowa state medical society journal, July 1922, v. 12, p. 259.

Farrell, E. E., M.D. Improper classification as a prime cause of delinquency. The Ounce, Sept. 1922, v. 1, no. 6, p. 1, 6.

Ferenczi, Sandor, M.D. Symbolism of the bridge. International journal of psychoanalysis, June 1922, v. 3, p. 163–68.

Fernald, W. E., M.D. Inauguration of a state-wide public-school mental clinic in Massachusetts. Mental hygiene, July 1922, v. 6, p. 471–86.

Firth, V. M. Machinery of the mind. N. Y., Dodd, 1922. 98 p.

Fosbroke, G. E. Character revelations of mind and body. N. Y., Putnam, 1922. 198 p.

Franz, S. I. Psychology and psychiatry. Psychological review, July 1922, v. 29, p. 241–49.

Freud, Sigmund. Introductory lectures on psychoanalysis; translated by Joan Riviere. Lond., Allen, 1922. 395 p.

Fuller, Sir Bampfylde. The science of ourselves. N. Y., Oxford university press, 1922. 326 p.

Genil-Perrin, G., M.D. La vie de la Ligue d'Hygiene Mentale. Bulletin de Ligue d'hygiene mentale, July–Oct. 1921, no. 1–2, p. 10–15.

Givler, R. C. Psychology; the science of human behavior. N. Y., Harper, 1922. 382 p.

Glueck, Bernard, M.D. New approach to the offender; understanding his personality. The World tomorrow, Aug. 1922, v. 5, p. 236–37.

Goddard, H. H. School training of defective children. Lond., Harrap, 1922. 98 p.

Goldberg, J. A. Incidence of insanity among Jews. Mental hygiene, July 1922, v. 6, p. 598–602.

Gordon, Alfred, M.D. Prevention of mental disease. Pennsylvania medical journal, June 1922, v. 25, p. 630–32.

Grant, H. M. An approach to mental hygiene problems through elementary and secondary education. American journal of nursing, Sept. 1922, v. 22, p. 1064–74.

Hamilton, S. W., M.D. Relation of the general practitioner to mental disorders. American physician, July 1922, v. 27, p. 499–501.

Harrison, G. M. Physical education of the mentally defective child. Studies in mental inefficiency, April 15, 1922, v. 3, p. 25–31.

Healy, William, M.D. Study of the case preliminary to treatment. Journal of criminal law and criminology, May 1922, v. 13, p. 74–81.

Hendricks, H. V., M.D. The general practitioner and medical certificates of insanity. Journal of the Michigan medical association, 1922, v. 21, p. 67–72.

Herring, J. P. Herring revision of the Binet-Simon tests; examination manual; form A. Yonkers, World book co., 1922. 56 p.

Hinkle, B. M. Spiritual significance of psychoanalysis. British journal of psychology, April 1922, v. 2, p. 165.

Hollander, Bernard, M.D. Psychology of misconduct, vice and crime. Lond., Allen, 1922.

Humphrey, E. F. Classifying therapeutic occupations from the standpoint of mental patients. Modern hospital, June 1922, v. 18, p. 554–56.

Hungarian psychiatry. The Lancet, Aug. 19, 1922, v. 203, p. 415.

Jacobsen, J. M. The special school in Norway and work connected with it. Studies in mental inefficiency, April 15, 1922, v. 3, p. 25–31.

Jatho, E. R. Mental hygiene for children; the medical aspects. Indiana bulletin of charities and correction, June 1922, p. 101–04.

Jelliffe, S. E., M.D. A neuropsychiatric pilgrimage. Journal of nervous and mental disease, Sept. 1922, v. 56, p. 239–48.

Jelliffe, S. E., M.D., and Louise Brink. Psychoanalysis and the drama. N. Y., Nervous and mental disease pub. co., 1922. 162 p.

Jones, E. K. The Library in the mental hospital. Modern hospital, June 1922, v. 18, p. 535–36.

Kitson, H. D. A critical age as a factor in labor turnover. Journal of industrial hygiene, Sept. 1922, v. 4, p. 199–202.

Kornhauser, A. W. Some business applications of a mental alertness test. Journal of personnel research, July 1922, v. 1, p. 103–21.

Kraepelin, Emil. German research institute. Journal of nervous and mental disease, Sept. 1922, v. 56, p. 207–14.

Laird, D. A. Talks by a psychologist; the mechanism of sublimation, how to use suggestion. Trained nurse and hospital review, July 1922, v. 49, p. 25–29.

Laird, D. A. Talks by a psychologist; instincts and the patient. Trained nurse and hospital review, Sept. 1922, v. 69, p. 207–11.

Lange, C. G., and William James. The emotions. Balt., Williams, 1922. 134 p.

Loosmore, W. C. Gain of personality; a popular psychological statement of the practical values of personality. N. Y., Dutton, 1922. 238 p.

MacCurdy, J. T., M.D. General etiologic factors in alcoholic psychoses. British medical journal, Aug. 5, 1922, v. 2, p. 204.

McDonald, J. E. F. Some aspects of insanity. Medical journal of Australia, April 15, 1922, v. 1, p. 399–403.

McDougall, William. New theory of laughter. Psyche, 1922, v. 2, p. 292.

McDougall, William. Use and abuse of instinct in social psychology. Journal of abnormal psychology and social psychology, Dec. 1921–March 1922, v. 16, p. 285–333.

Mackin, M. C., M.D. State care vs. county care of the insane. Iowa bulletin of state institutions, Jan. 1922, v. 24, p. 50–55.

Marsden, K. L. Classes for dull and backward children. Studies in mental inefficiency, July 15, 1922, v. 3, p. 55–61.

Massoneau, Grace. Social analysis of a group of psychoneurotic ex-service men. Mental hygiene, July 1922, v. 6, p. 575–91.

Mathers, A. T., M.D. The broadening scope of mental medicine. Canadian medical association journal, June 1922, v. 12, p. 371–76.

May, J. V., M.D. Mental diseases, a public health problem; with a preface by T. W. Salmon. Boston, Badger, 1922. 544 p.

Meagher, J. F. W., M.D. Psychoanalysis and its critics. Psychoanalytic review, July 1922, v. 9, p. 324–36.

Miller, H. C., M.D. Parental care in adolescence. Medical officer, June 3, 1922, v. 27, p. 234.

Mott, Sir F. W., M.D. Alcohol in its relation to problems of mental disorder. British medical journal, Aug. 5, 1922, v. 2, p. 199.

Moyer, H. N. What is psychoanalysis? Health, June 1922, v. 2, p. 19–22.

Myers, C. S. Nature and development of the sentiments. Psyche, 1922, v. 2, p. 196.

National Committee for Mental Hygiene. Report of the mental survey of Cincinnati, made under auspices of the Mental Hygiene Council of the Public Health Federation of Cincinnati. 1922. 130 p.

Nicole, J. E., M.D. Psychoanalytical schools, old and new. The Lancet, Aug. 12, 19, 1922, v. 203, p. 349–52, 406–09.

Nixon, C. E., M.D. Study of individuality. Mental hygiene, July 1922, v. 6, p. 603–06.

Norman, H. J., M.D. Lunacy reform. Hospital and health review, July 1922, n. s. v. 1, p. 285–86.

Parsons, F. W., M.D. Ward management in relation to non-restraint and seclusion. State hospital quarterly, May 1922, v. 7, p. 301–03.

Paton, Stewart, M.D. Signs of sanity and the principles of mental hygiene. N. Y., Scribner, 1922. 241 p.

Pfeifer, S. Disappointment in love during analysis. International journal of psychoanalysis, June 1922, v. 3, p. 175–79.

Pfister, Oskar. Plato, a forerunner of psychoanalysis. International journal of psychoanalysis, June 1922, v. 3, p. 169–74.

Pollock, H. M. Personnel relations in state hospitals. Mental hygiene, July 1922, v. 6, p. 592–97.

Popenoe, Paul. Eugenics and human morality. Journal of heredity, Feb. 1922, v. 13, p. 77–81.

Potter, H. W., M.D. Personality in the mental defective, with a method for its evaluation. Mental hygiene, July 1922, v. 6, p. 487–97.

Pratt, G. K., M.D. Problem of the mental misfit in industry. Mental hygiene, July 1922, v. 6, p. 526–38.

Protection of the race against multiplication of mentally defective. Journal of the American medical association, July 1922, v. 79, p. 313–14.

Psychological tests in library examinations. Library journal, Sept. 1922, v. 47, p. 717–18.

Raynor, M. W., M.D. Organization of social work in a state hospital. State hospital quarterly, May 1922, v. 7, p. 319–25.

Richardson, C. A. Methods and experiments in mental tests. Lond., Harrap, 1922. 94 p.

Roheim, G. Psychoanalysis and the folk-tale; a rejoinder to a recent critic. International journal of psychoanalysis, June 1922, v. 3, p. 180–86.

Ryon, W. G., M.D. Occupational therapy as a means of controlling disturbed patients. State hospital quarterly, May 1922, v. 7, p. 293–300.

Sands, I. J., M.D. Personality defects as neuropsychiatric problems. N. Y. state journal of medicine, July 1922, v. 22, p. 323–27.

Sands, I. J., M.D. and Phyllis Blanchard. Some of the psychological mechanisms of human conduct. Mental hygiene, July 1922, v. 6, p. 498–521.

Sanz, E. F. Organization in Spain of a League of mental hygiene and protection of the insane. Siglo méd., Madrid, June 3, 1922, v. 69, p. 592.

Saxby, I. B. Education of behavior. London, University of London press, 1921. 248 p.

Schade, H. Pioneer insane asylum, 1442. Nederlandsch Tijdschrift v. Geneeskunde, May 6, 1922, v. 1, p. 1803.

Schwab, S. I., M.D. Rôle of mental hygiene in education. Nation's health, Aug. 1922, v. 4, p. 471–76.

Scott, M. F. Meeting your child's problems. Boston, Little, 1922. 231 p.

"Shell shock" and "cowardice". The Lancet, Aug. 19, 1922, v. 203, p. 399–400.

Spear, M. R., and H. J. Garrison. Occupational and recreational therapy at the Kalamazoo state hospital. Modern hospital, June 1922, v. 18, p. 556–58.

Stearns, A. W., M.D. Relation of feeblemindedness to a criminal career. Archives of neurology and psychiatry, Sept. 1922, v. 8, p. 326–29.

Stragnell, Gregory, M.D. A psychopathological study of Knut Hamsuns "Hunger". Psychoanalytic review, April 1922, v. 9, p. 198–217.

Suttie, J. I., and I. D. Consideration of some of claims of new Nancy school. Glasgow medical journal, July 1922, v. 118, p. 36.

Sutton, B. E. Problems of occupational therapy in a state hospital. Minnesota educational quarterly, May 2, 1922, v. 21, p. 20–30.

Terman, L. M. New approach to the study of genius. Psychological review, July 1922, v. 29, p. 310–18.

Thom, D. A., M.D. Habit clinics for children of the pre-school age. Mental hygiene, July 1922, v. 6, p. 463–70.

Toulouse, Edouard, M.D. Insanity and mental hygiene. Rational living, 1922, p. 15–28.

Toulouse, Edouard, M.D. Le program de la Ligue d'Hygiene Mentale. Bulletin de la Ligue d'hygiene mentale, July–Oct. 1921, no. 1–2, p. 1–5.

Townsend, H. G. Concept of inferiority. School and society, Feb. 4, 1922, v. 15, p. 134–38.

Waters, P. S., M.D. A plea for small group care of the insane. Modern hospital, July 1922, v. 19, p. 15–17.

Williams, F. E., M.D. Mental hygiene and mustard plasters. American journal of nursing, June 1922, v. 22, p. 739–43.

Wolfe, Samuel, M.D. Mental instability in ex-service men; how acquired, how remedied. Military surgeon, July 1922, v. 51, p. 44–46.

Wolff, Bernard, M.D. Psychic peculiarities of the negro. Urological and cutaneous review, Sept. 1922, v. 26, p. 547–50.

Woolcott, Alexander. Invisible wounds. American legion, March 24, 1922, v. 4, no. 12, p. 5–6, 18–19.

DIRECTORY OF COMMITTEES AND SOCIETIES FOR MENTAL HYGIENE

National Organizations

The National Committee for Mental Hygiene, Inc.
370 Seventh Avenue, New York City
Dr. Frankwood E. Williams, Medical Director
Dr. V. V. Anderson, Director, Division on Prevention of Delinquency
Dr. Thomas H. Haines, Director, Division on Mental Deficiency
Dr. Clarence J. D'Alton, Executive Assistant
Clifford W. Beers, Secretary
Paul O. Komora, Assistant Secretary
Edith M. Furbush, Statistician

The Canadian National Committee for Mental Hygiene
103 College Street, Toronto, Canada
Dr. C. K. Clarke, Medical Director
Dr. C. M. Hincks, Associate Medical Director and Secretary
Dr. Gordon S. Mundie, Associate Medical Director

State Organizations

Alabama Society for Mental Hygiene
Dr. W. D. Partlow, Secretary, Tuscaloosa, Alabama

California Society for Mental Hygiene
Miss Julia George, Secretary
1136 Eddy Street, San Francisco, Cal.

Connecticut Society for Mental Hygiene
39 Church Street, New Haven, Conn.
Otto T. Wiedman, Medical Director
Mrs. Helen M. Ireland, Secretary

District of Columbia Society for Mental Hygiene
Dr. D. Percy Hickling, Secretary
1305 Rhode Island Avenue, Washington, D. C.

Georgia Society for Mental Hygiene
In process of organization
Dr. N. M. Owensby, Secretary.
Peters Building, Atlanta, Ga.

Illinois Society for Mental Hygiene
5 North Wabash Avenue, Chicago, Ill.
Dr. Ralph P. Truitt, Medical Director

Indiana Society for Mental Hygiene
Paul L. Kirby, Secretary
88 Baldwin Block, Indianapolis, Ind.

Iowa Society for Mental Hygiene
(Not yet active.)

Kansas Society for Mental Hygiene
Dr. Florence B. Sherbon, Secretary
Mulvane Building, Topeka, Kansas

Louisiana Society for Mental Hygiene
Dr. Maud Loeber, Secretary
1424 Milan Street, New Orleans, La.

Mental Hygiene Society of Maryland
130 So. Calvert Street, Baltimore, Md.
Dr. Chas. B. Thompson, Exec. Secretary

Massachusetts Society for Mental Hygiene
1133 Kimball Building, 18 Tremont Street, Boston, Mass.
Dr. George K. Pratt, Medical Director

Maine Society for Mental Hygiene
In process of organization. Address Dr. F. C. Tyson, Augusta, Maine

Mississippi Society for Mental Hygiene
Dr. J. H. Fox, Secretary
Jackson, Mississippi

Missouri Society for Mental Hygiene
Dr. James F. McFadden, Secretary
Humboldt Building, St. Louis, Mo.

Committee on Mental Hygiene of the New York State Charities Aid Association
105 East 22d Street, New York City
Stanley P. Davies, Exec. Secretary

North Carolina Society for Mental Hygiene
Dr. Albert Anderson, Secretary
Raleigh, N. C.

Oregon Society for Mental Hygiene
Professor Samuel C. Kohs, Secretary
Portland, Oregon

Committee on Mental Hygiene of the Public Charities Association of Pennsylvania
419 South 15th Street, Philadelphia, Pa.
Kenneth L. M. Pray, Secretary

Rhode Island Society for Mental Hygiene
Miss Mary C. Greene, Secretary
9 Exchange Terrace, Providence, R. I.

Tennessee Society for Mental Hygiene
C. C. Menzler, Secretary
Nashville, Tenn.

Virginia Society for Mental Hygiene
Dr. William F. Drewry
Petersburg, Virginia

Members and Directors

of

THE NATIONAL COMMITTEE FOR MENTAL HYGIENE, INC.

(Directors indicated by asterisks before their names.)

Mrs. Milo M. Acker, Hornell, N. Y.
Jane Addams, Chicago
Dr. Herman M. Adler, Chicago
*Edwin A. Alderman, Charlottesville, Va.
Harriet Bailey, Bangor, Me.
Dr. Charles P. Bancroft, Concord, N. H.
*Otto T. Bannard, New York
*Dr. Lewellys F. Barker, Baltimore
Dr. Albert M. Barrett, Ann Arbor, Mich.
David P. Barrows, Berkeley, Cal.
Dr. Clara Barrus, West Park, N. Y.
Dr. Herman M. Biggs, New York
*Dr. Frank Billings, Chicago
Dr. Robert H. Bishop, Cleveland
Dr. Malcolm A. Bliss, St. Louis
Dr. Rupert Blue, Washington
*Dr. George Alder Blumer, Providence
Dr. Eugene D. Bondurant, Mobile, Ala.
*Dr. Samuel A. Brown, New York
Dr. Edward N. Brush, Baltimore
William H. Burnham, Worcester
Nicholas Murray Butler, New York
*Dr. C. Macfie Campbell, Boston
Dr. Louis Casamajor, New York
F. Stuart Chapin, Minneapolis
*Russell H. Chittenden, New Haven
Dr. Edmund A. Christian, Pontiac, Mich.
*Dr. L. Pierce Clark, New York
*Dr. William B. Coley, New York
*Dr. Owen Copp, Philadelphia
Dr. George W. Crile, Cleveland
Dr. Harvey Cushing, Boston
*Dr. Charles L. Dana, New York
*C. B. Davenport, Cold Spring Harbor
Dr. George Donohoe, Cherokee, Iowa
*Stephen P. Duggan, New York
Mrs. William F. Dummer, Chicago
Dr. David L. Edsall, Boston
*Charles W. Eliot, Cambridge
Dr. Charles P. Emerson, Indianapolis
Dr. Haven Emerson, New York
Dr. Livingston Farrand, Ithaca
Elizabeth E. Farrell, New York
W. H. P. Faunce, Providence
Katherine S. Felton, San Francisco
*Dr. Walter E. Fernald, Waverley, Mass.
John H. Finley, New York
Dr. J. M. T. Finney, Baltimore
Irving Fisher, New Haven
*Matthew C. Fleming, New York
*Homer Folks, New York
Raymond B. Fosdick, New York
Lee K. Frankel, New York
Dr. Charles H. Frazier, Philadelphia
Dr. C. Lincoln Furbush, Philadelphia
Francis D. Gallatin, New York
Dr. Arnold L. Gesell, New Haven
Dr. Bernard Glueck, New York
Dr. J. E. Goldthwait, Boston
Dr. S. S. Goldwater, New York
Dr. Menas S. Gregory, New York
Arthur T. Hadley, New Haven
Dr. Arthur S. Hamilton, Minneapolis
Learned Hand, New York
Mrs. E. Henry Harriman, New York
*Dr. C. Floyd Haviland, Albany
Dr. Harley A. Haynes, Lapeer, Mich.
Dr. William Healy, Boston
Dr. Arthur P. Herring, Baltimore
Frederick C. Hicks, Cincinnati
Charles W. Hoffman, Cincinnati
*William J. Hoggson, Greenwich, Conn.
Dr. L. Emmett Holt, New York
Franklin C. Hoyt, New York
Surg. Gen. M. W. Ireland, Washington
*Dr. Walter B. James, New York
Mrs. Helen Hartley Jenkins, New York
Harry Pratt Judson, Chicago
Dr. Charles G. Kerley, New York
*Dr. George H. Kirby, New York
Franklin B. Kirkbride, New York
James H. Kirkland, Nashville
Dr. George M. Kline, Boston
Dr. Augustus S. Knight, Gladstone, N. J.
Julia C. Lathrop, Rockford, Ill.
Burdette G. Lewis, Trenton, N. J.
Adolph Lewisohn, New York
Ernest H. Lindley, Lawrence, Kansas
*Samuel McCune Lindsay, New York
Dr. Charles S. Little, Thiells, N. Y.
Dr. William F. Lorenz, Madison, Wis.
Tracy W. McGregor, Detroit
George P. McLean, Simsbury, Conn.
Henry N. MacCracken, Poughkeepsie, N. Y.
Dr. Carlos F. MacDonald, New York
V. Everit Macy, Scarborough, N. Y.
Richard I. Manning, Columbia, S. C.
Marcus M. Marks, New York
Maude E. Miner, New York
Dr. Henry W. Mitchell, Warren, Pa.

Dr. George A. Moleen, Denver
Mrs. William S. Monroe, Chicago
Dwight W. Morrow, Englewood, N. J.
Dr. J. Montgomery Mosher, Albany
Dr. J. M. Murdoch, Polk, Pa.
J. Prentice Murphy, Philadelphia
William A. Neilson, Northampton, Mass.
Dr. Frank P. Norbury, Springfield, Ill.
Dr. Samuel T. Orton, Iowa City
William Church Osborn, New York
Harry V. Osborne, Newark, N. J.
Dr. Herman Ostrander, Kalamazoo, Mich.
Dr. William H. Park, New York
*Dr. Stewart Paton, Princeton
Dr. Hugh T. Patrick, Chicago
Dr. Frederick Peterson, New York
Henry Phipps, New York
Gifford Pinchot, Philadelphia
Roscoe Pound, Cambridge
Dr. M. P. Ravenel, Columbia, Mo.
Rush Rhees, Rochester, N. Y.
Dr. Robert L. Richards, San Francisco, Cal.
Dr. Austen F. Riggs, Stockbridge, Mass.
Dr. Milton J. Rosenau, Boston
Ira C. Rothgerber, Denver
*Mrs. Charles C. Rumsey, Wheatley Hills
*Dr. William L. Russell, White Plains
*Dr. Bernard Sachs, New York
*Dr. Thomas W. Salmon, New York
Jacob Gould Schurman, Ithaca
Dr. Sidney I. Schwab, St. Louis
Carl E. Seashore, Iowa City
Edward W. Sheldon, New York
Dr. H. Douglas Singer, Chicago
Dr. Edith R. Spaulding, New York
Dr. M. Allen Starr, New York
Dr. Henry R. Stedman, Boston
*Anson Phelps Stokes, Lenox, Mass.
Dr. Charles F. Stokes, New York
Dr. Frederick Tilney, New York
Howard B. Tuttle, Naugatuck, Conn.
*Victor Morris Tyler, New Haven
Dr. Forrest C. Tyson, Augusta, Me.
*Mrs. William K. Vanderbilt, New York
Henry van Dyke, Princeton
Dr. Henry P. Walcott, Cambridge
Lillian D. Wald, New York
Dr. George L. Wallace, Wrentham, Mass.
*Dr. William H. Welch, Baltimore
Dr. William A. White, Washington
Dr. Ray Lyman Wilbur, Stanford, Cal.
Dr. Henry Smith Williams, New York
Dr. William H. Wilmer, Washington
Dr. C.-E. A. Winslow, New Haven
Arthur Woods, New York
Robert A. Woods, Boston
Howell Wright, Cleveland
*Robert M. Yerkes, Washington
Dr. Edwin G. Zabriskie, New York

INDEX OF AUTHORS AND SUBJECTS

ABSTRACTS AND REVIEWS

LISTED BY AUTHORS OF BOOKS AND ARTICLES